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EXECUTIVE SUMMARY

The purpose of this report is to summarize the progress achieved in serving **Willie M.** clients over the past year and to provide the General Assembly with required information on the operation of the **Willie M.** Program. The key highlights of this year's report are:

The number of Willie M. children continues to grow.

- The number of currently eligible **Willie M.** children grew to 1,598 at the close of 1998. This represents a 5 percent increase from the prior year and a 49 percent increase over the last six years. Due to continued growth in the number of children in North Carolina and key social trends, further growth in the number of clients is expected.

Willie M. children continue to be very *high-risk* children, although they are acquiring more *protective factors* to help them cope with the numerous risks present in their lives.

- Evidence from a variety of evaluative measures continues to show that **Willie M.** members are very *high-risk* children with respect to their ability to function normally in society, now and in the future. On average, current **Willie M.** children have been identified as having 13 different "risk factors" which predict poor outcomes later in life. Research has shown that the presence of four or more risk factors places a child at "high-risk" for poor results later in life.

- "Protective factors" help lessen the effects of risk factors by providing a strong base which allows them to avoid poor outcomes such as criminal involvement, mental illness, and substance abuse. **Willie M.** children who have been in the program through at least two formal evaluations have averaged adding 7 new protective factors for an average total of 20. Progress is particularly evident in the areas of social skills and social support.

The average cost of serving a Willie M. child has leveled off at just over $50,000 per year.

- Total expenditures for the **Willie M.** program totaled $87.2 million in Fiscal Year 1997-98. Of this total, $6.1 million was granted to local schools by the Department of Public Instruction, $78.3 million provided treatment services through the Department of Health and Human Services, and the remaining $2.8 million covered state administration, program evaluation, and training activities.

- The statewide-adjusted average cost of DHHS treatment services per child was $51,456 in Fiscal Year 1997-98. This was actually slightly lower than the previous year's adjusted cost. The costs are adjusted to account for the fact that many clients are only in the program for part of the year because they are newly certified or age out when turning 18. As in previous years, costs per child varied significantly, with eleven percent of all clients costing over $100,000 per child and over forty-six percent costing less than $25,000 per child. These differences are caused by the need for much more intensive services, especially residential services, for some clients.

Willie M. children are making progress toward improved functioning in the community. Assessment of new data collected in the last few years shows promising results.

- As a result of client outcome monitoring implemented over the last several years, we now have better information on the progress of **Willie M.** children. Evaluation shows that **Willie M.** clients are making progress in all six of the major life domains studied: Residential, Health, Behavioral, Social, Educational, and Legal. Progress appears most evident in moving children to less restrictive residential settings, reducing violent or aggressive behavior, reducing contact with legal agencies, and keeping **Willie M.** clients in school. The progress appears lasting and greater the longer children are in the program. Finally, progress is greatest for those children who enter the program with the worst problems.

SECTION ONE

HISTORY AND OBJECTIVES OF THE **WILLIE M.** PROGRAM

This report provides an overview of the purpose, history, and objectives of the **Willie M.** Program. More importantly, this report addresses the specifics of **Willie M.** operations and describes the progress being achieved in serving this special population of clients. The focus of this section is:

- the purpose and structure of the report;
- a brief history of the **Willie M.** Program;
- an explanation of how a child becomes a **Willie M.** client;
- the goals of the program for individual clients; and
- the management of the **Willie M.** Program.

A. Purpose and Structure of This Report

This report fulfills an in-place statutory requirement. Since 1984 the annual Appropriations Act has required the Department of Health and Human Services (DHHS)[1] and the Department of Public Instruction (DPI) to apprise the Governor and General Assembly of progress made in meeting the special needs of the **Willie M.** children. The report includes a number of specific and detailed data requirements and also provides information to the general public about how the system is meeting its responsibilities.

The report describes the **Willie M.** Program, the children being served, the services provided, the costs of those services, and progress being achieved by the children. It is sub-divided into five sections.

- **Section 1** presents a **brief overview** of the program with comment on its history, objectives, and management.
- **Section 2** characterizes the **clients being served** and includes data presentations related to numbers of clients, their demographics, and psychosocial conditions.
- **Section 3** describes the in-place **service system** and comment on its design.
- **Section 4** reports program operation **costs** and shares information on high-cost children, waivers granted to reimbursement rules, and other State funds expended in support of **Willie M.** clients.

[1] The Department of Health and Human Services (DHHS) was newly named in 1997. Prior to this time the name was the Department of Human Resources (DHR). The latter name is used in this report when it refers to actions taken place before 1997.

- Finally, **Section 5** summarizes important information about the **progress** and status of **Willie M.** children with regards to basic objectives for improving their ability to function in society.

B. Brief History of the **Willie M.** Program

Willie M. was one of four children for whom a class action lawsuit was filed in October 1979. The plaintiffs, all minors, sought the right to receive treatment and educational services that had repeatedly been denied. Because these children had a history of violent behavior and mental or emotional handicaps, they were often blocked from entering, or asked to leave, programs that were not really designed to meet their needs. After repeated, unsuccessful efforts by attorneys, social workers, judges, and others to obtain services, the plaintiffs concluded that the State of North Carolina would continue to deny services to these children unless forced to do so through litigation.

In the lawsuit, the plaintiffs defined the children they were representing as every North Carolina citizen under 18 who fits all of the following:

- now, or will in the future, suffer from serious emotional, mental, or neurological handicaps;
- exhibits violent or assaultive behavior;
- is, or will be, involuntarily institutionalized; and
- is not receiving appropriate treatment and education services.

The defendants were State government officials, including the Governor, the Secretary of the Department of Human Resources, the State Superintendent of Public Instruction, and the Chairman of the North Carolina Board of Education.

In September 1980, both parties worked out a settlement in which the Defendants agreed to identify and provide appropriate services to all children meeting the criteria stated in the lawsuit. The Federal Court established a Review Panel to monitor and oversee the State's implementation of the Consent Decree.

During the ensuing years, the involved State agencies, with the assistance of the General Assembly, established a program of services across North Carolina to serve class members. The 1995 General Assembly enacted legislation [N.C.G.S. 122C-3(13a)] defining clients eligible for **Willie M.** services in a manner consistent with the definition in the original lawsuit. In addition, legislation authorized DHR to adopt rules governing determination of eligibility for services, ensuring provision of services and providing for contested case hearings [N.C.G.S. 122C-194-200]. These actions by the General Assembly were made in an attempt to enable the State to assume complete responsibility for the operation of the **Willie M.** Program without continued oversight by the Federal Court. The Division of Mental Health,

Developmental Disabilities, and Substance Abuse Services implemented the rules, effective March 1, 1997 [N.C. Administrative Code T10: 14V.7000] which covered:

- Detailed eligibility criteria for services;
- Application and eligibility determination procedures;
- Needs assessment, service planning and service provision requirements;
- Area program and Division requirements;
- Procedures for providing prior notice to parents of proposed changes in the service plan or services;
- Procedures for responding to and resolving disputes about a child's needs assessment, service plan or services (including the availability of third party mediation, the right to file a petition for a contested case hearing, and administrative review by a departmental review officer).

Shortly after passage of the new statute, the Department of Human Resources adopted Administrative Rules for the administration of the **Willie M.** Program. These two actions allowed the State of North Carolina to make a Motion to the Federal Court in January 1997 that the Court find the State in compliance with the directives of the Court and dismiss the case, thus ending the need for continued oversight.

On January 22, 1998, Judge Graham Mullen ordered the dismissal of the **Willie M.** Consent Decree and lawsuit. Judge Mullen found that the State's program of services for **Willie M.** class members complied with the Court's Decree "to the extent practicable." He further found that changes in law, since the Consent Decree was signed in 1980, removed the basis for Federal Court jurisdiction in the case. While noting that change in federal law removes this case from federal jurisdiction, Judge Mullen emphasized the State's obligations to serve these children under State law. He noted that the statute remains subject to enforcement by State Courts.

The end of the lawsuit did not mean the end of the State's commitment to identify and serve children and adolescents with serious mental, neurological, or emotional disabilities accompanied by violent or aggressive behavior. It simply means that the State now exercises its responsibilities to serve these children without the oversight of the Federal Court. Children with service needs continue to reside across the State of North Carolina. Prior to the intervention of the Federal Court these children were shuffled off to training schools, state hospital wards, or inappropriate home placements with little or no attention given to their unique problems and disabilities. Today an integrated system of care is in place. These children are appropriately provided for through a system of services that is unsurpassed in the nation.

C. How Children Become **Willie M.** Clients

Anyone who knows a child and is familiar with his problems may request that the child be considered for **Willie M.** services. A nomination/application form is usually submitted to the child's area mental health center where staff assist with completion of the application form, obtain consent form signatures, and gather supportive documentation.

Since **Willie M.** Program participation is voluntary, the child's parent or legal guardian must provide consent before a child can be found eligible for services. The child's application will be halted if consent is withdrawn at any time during the eligibility process. Once the parent or guardian grants consent and the information necessary to demonstrate the child's need for services is collected, the application is sent to the **Willie M.** Section in Raleigh for a determination of eligibility. Section staff, with the assistance of contracted specialists, review the application and render a decision on eligibility. If the child meets all eligibility criteria, the Section determines the child as eligible for services and notifies all relevant parties of the decision. The local Area Mental Health Program staff quickly begin the treatment planning process in order to assure the delivery of appropriate services.

If the child does not meet all of the criteria, the application/nomination is not accepted, and all parties are notified of this decision and the reasons for it. If the applying party or the parent/guardian has additional information to offer in support of the nomination, the application may be reactivated on their request. The State staff will reconsider the application, render a decision, and notify all parties of the decision. If the applying party disagrees with the decision, he/she may appeal the decision through the Program's Contested Case Hearing Process.

The application process has remained essentially the same throughout the history of the program. Since 1981, over 10,000 children have been nominated for program membership and more than 5,600 have been found eligible as clients.

D. Program Goals for Individual Clients

The **Willie M.** Program does not guarantee a "cure" to children accepted for services. Rather, the State agencies with responsibility for these children have always attempted to design and deliver services that have positive long-term impacts on a child's functioning.

Following this reasoning the General Assembly directed DHR and DPI in 1992 to develop a plan to achieve compliance with the lawsuit and to collect and report on whether **Willie M.** children made progress while receiving services. Along with an overall plan for achieving compliance, DHR and DPI developed a statement of desired outcomes for **Willie M.** clients at age 18. Although no one can guarantee

successful outcomes for all of these children, the State adopted the following service goals:

- Education - The client attends and participates in educational services appropriate to his/her needs.
- Health - The client will, to the extent that he/she is able, maintain a state of health sufficient for his participation in normal, productive, and rewarding activities.
- Housing/Residential - The client has a "home," even if it is not his/her natural home, which provides him/her with a safe, nurturing environment conducive to the achievement of all of his/her other goals and objectives.
- Social - The client has at least one person who is also an advocate, friend, and confidant who maintains a long-term relationship with the child, fostering trust, self-esteem, and social competence.
- Vocation - The client is engaged in meaningful employment in a real work setting of his/her choice, or in activities leading toward that goal.
- Behavior - The client develops the social competence and coping skills he/she needs in order to reduce or ameliorate assaultive and aggressive behaviors.

In 1994, DHR began collecting simple measures of current functioning among **Willie M.** clients and has collected the same information on all certified clients since then. Starting in 1995, DHR began annual formal assessments of each child's current functioning, as well as an inventory of the conditions and experiences which put the child *at-risk* for poor outcomes in life as well as *protective factors* which might reduce such poor outcomes. Results from these ongoing assessment activities are presented in Section 5 of this report.

E. Management of the **Willie M.** Program

The **Willie M.** Program now encompasses over 1,600 active clients, over $87.2 million in State and federal funding, and thousands of people working full or part time all over North Carolina to serve this very difficult population. The management of this large and complex endeavor is based on a commitment to quality, efficiency, and results. All associated agencies have invested significant resources in quality improvement efforts so that they may ensure that public funds are spent in ways that provide the maximum opportunity for clients to heal, develop, and progress into productive adulthood.

The quality improvement philosophy under which the program is managed requires that a variety of data collection and monitoring activities be conducted on a continuous basis. The purpose of these activities is to learn as much as possible about the problems our clients face, the services they receive, the costs of those services,

the outcomes they achieve, and the factors associated with good or bad outcomes. These types of findings enable program staff to adjust service packages, clinical practices, organizational and financial arrangements, training needs, and other aspects of the system to better serve the client.

Because the **Willie M.** Program has always maintained a focus on the individual child, his/her particular needs, and his/her service planning, much of the Section's monitoring system is directed toward collecting data on the individual child's needs, the services being provided, and the outcomes achieved. In order to achieve the best outcomes for all children and in order to ensure cost-effective service provision, the program staff must also monitor how whole systems of services perform for large groups of clients. This causes the **Willie M.** Section staff to prepare aggregate statistics on children, services, and expenditures. Additionally, the Section monitors the performance of local agencies involved in and supporting the delivery of **Willie M.** services. Moreover, the Section monitors trends in demographics, social problems and service practices in the larger human services world and general society. The system monitoring results are used to design service system improvements and enhance clinical knowledge and practice approaches. In addition, the results are relied upon to report to the general public, as it is this group to whom the system is ultimately accountable.

SECTION TWO

DESCRIPTION OF **WILLIE M.** CLIENTS

This section of the report describes the more than 1,600 children across North Carolina who have qualified as **Willie M.** clients. It includes specific information on:

- the number of clients served,
- the demographic characteristics of the clients,
- the psychosocial characteristics of the clients, and
- the reasons for the growth in the number of **Willie M.** clients.

A. Number of **Willie M.** Clients

The number of **Willie M.** clients has been growing. As of December 31, 1998, there were 1,598 eligible **Willie M.** clients. This represented an increase of more than 5 percent over the previous year-end total. During fiscal year 1997-1998, the **Willie M.** Program served 1,929 clients. The number of clients served in a particular year is always higher than the number of clients eligible at a given point in time due to new determinations of eligibility and clients turning 18, or "aging out," during the year so that they are no longer eligible. TABLE 1 shows the number of certified eligible children by calendar year as well as the number of new applications and new determinations of eligibility. The number of children currently eligible has been growing over time with most of the growth occurring in the last six years, a 49 percent increase in currently eligible members since 1992.

TABLE 1
HISTORY OF NOMINATIONS, CERTIFICATIONS, AND ELIGIBLE CLIENTS BY CALENDAR YEAR

Period Ending	Number Nomina-ted	Number Newly Certified	Number Certified Eligible Clients End of Period
Through 1982	2,572	1,074	982
1983	609	280	1,073
1984	466	280	1,099
1985	451	256	1,095
1986	478	240	1,080
1987	360	195	1,052
1988	393	215	1,022
1989	464	268	1,069
1990	477	208	1,037
1991	459	218	1,034
1992	426	274	1,070
1993	456	357	1,202
1994	391	214	1,189
1995	494	333	1,244
1996	640	395	1,408
1997	604	437	1,523
1998	536	354	1,598

Because of the importance of this growth and its connection to other changes in program membership, the issue of growth is discussed in greater detail later in this section of the report (See Section E, page 21).

Applications and determinations of eligibility for services have also been increasing over time, although both declined in the last year. There were 536 children newly nominated during 1997--a decrease of 11 percent from the prior year--and 354 were newly certified as eligible for services during the same period--a decrease of 19 percent from the prior year. However, the number of applications and determinations of eligibility has grown substantially over time. Over the past ten years the number of applications has increased by one-third, up 36 percent since 1988. Similarly the number of determinations of eligibility has climbed significantly, increasing by 65 percent in the same ten-year period.

The number of **Willie M.** children being served in public schools has followed the same pattern of growth. The Department of Public Instruction is responsible for ensuring that **Willie M.** clients receive appropriate educational services. These services are also provided in accordance with federal and state law governing programs for exceptional children. The vast majority of **Willie M.** students are classified as exceptional children and receive special education and related services through Local Educational Agencies (LEA).

A periodic headcount is conducted as a partial means of monitoring the educational services being provided in local educational agencies to program clients. The number of **Willie M.** children being served by LEAs as of June 15, 1998, was 1,366, a thirteen percent increase over the prior year (see TABLE 2). The number of program clients being served by LEAs is always less than the total number of clients because some children are being served in other educational settings such as state institutions and others are no longer in school. The number of clients being served by local school systems naturally shows the same upward trend as the entire program population over time, although it is increasing faster, up eighty-seven percent in the last six years. The reason for this faster increase is the greater proportion of **Willie M.** clients now being served in the public schools. In 1992, approximately sixty-eight percent of the certified clients were in public schools,

TABLE 2
NUMBER OF CHILDREN SERVED AND LOCAL EDUCATION AGENCIES (LEAS) PROVIDING SERVICE

Period Ending June 15th	Number of Clients Served by LEAs	Number of LEAs Providing Services
1991	770	100
1992	731	98
1993	853	104
1994	970	98
1995	1,008	99
1996	1,117	96
1997	1,205	102
1998	1,366	95

while in 1998 the number had climbed to eighty-five percent. Keeping program clients in school is one of the important goals for the Section.

B. Demographic Characteristics of **Willie M.** Clients

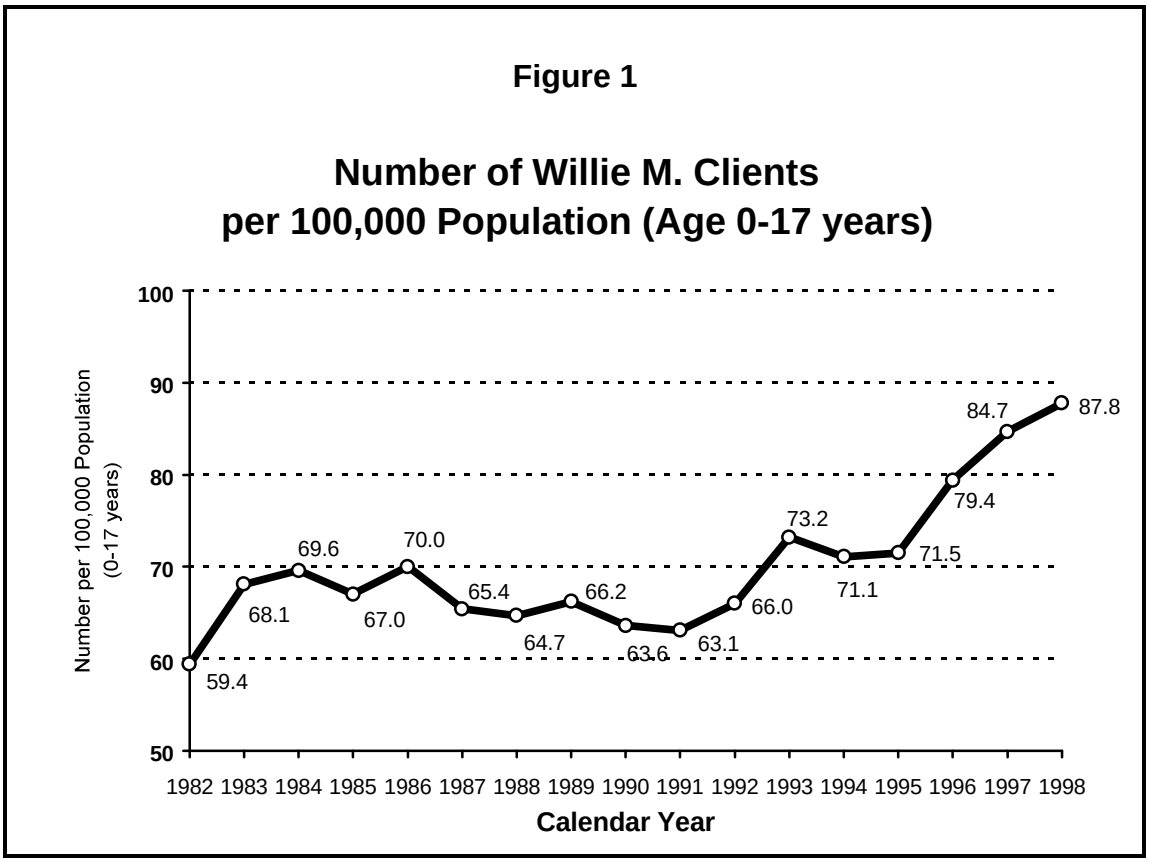
While the number of **Willie M.** clients has been increasing, the demographic characteristic of those being served has remained relatively stable over time. Program clients come from across the State and are predominantly teenage males.

1. Frequency of Willie M. Children in the General Population

The number of **Willie M.** children is fairly small when compared to the child population as a whole. With 1,598 program clients at the end of 1998, this is only 0.088 percent of the child population aged 0-17 in North Carolina, or roughly one **Willie M.** child for every 1,100 children in the State.

The number of **Willie M.** children relative to the population has been increasing. FIGURE 1 shows the number of currently eligible **Willie M.** children in North Carolina per 100,000 children by year since the Program's start. While the rate remained relatively stable in the early years, the frequency has noticeably

Figure 1



increased in the last few years. Before 1993, the rate never exceeded 70 **Willie M.** clients per 100,000 population. But, since that time it has not been below this level. The increase in the rate from 66.0 in 1992 to 87.8 in 1998 is thirty-two percent. This increase is caused in large part by an increasing number of applications and determinations of eligibility and by children being found eligible for services at a younger age. The younger the age at eligibility, the longer the time of program connected support.

2. Distribution of Willie M. Clients across North Carolina

Children being served by the **Willie M.** Program can be found all across the State. TABLE 3 shows the number of program clients who were eligible to receive services at the end of 1998 by their home area mental health program. The table also shows the frequency of eligible clients relative to the total child population in the respective areas.

Standardizing rates of certification per 100,000 population under 18, provides a perspective on how local catchment areas compare to one another. In particular, relative participation in the **Willie M.** Program for each local mental health catchment area can be measured against the state average listed in the last line of the table. There is a large range about the state average. Rutherford-Polk, the highest area in 1998, had a rate of participation relative to the youth population five times higher than the lowest area, Roanoke-Chowan. Differences are probably due to a combination of referrals, local administrative operation, and social demographics, but examination of the participation rates has not revealed a clear pattern that would explain the variation. Areas with the highest number of active certified children relative to the population include Foothills, Rutherford-Polk, Smoky Mountain, Vance-Granville-Franklin-Warren, Foothills, Rockingham, and Wayne. Areas with particularly low rates compared to the State include Roanoke-Chowan, Onslow, Albemarle, Wake, and Duplin-Sampson.

It is worth mentioning that although some local areas have high rates and others low ones, many programs have wide variations in their certification rates across time. This variation is more a reflection of relatively small numbers of clients in some local programs and of organizational and administrative changes within the local systems rather than changes in the characteristics of their youth population. Changes such as the emerging presence of managed care, shifts in the philosophical orientations of mental health practitioners, and changes in service composition in mental health and educational areas may account for fluctuations of certification rates over time. An examination of rates over time has shown that the range of rates across area programs has narrowed suggesting a higher degree of consistency across the State.

TABLE 3
LOCATION OF CERTIFIED ELIGIBLE WILLIE M. CLIENTS
BY AREA MENTAL HEALTH PROGRAM AS OF DECEMBER 1998

Area Program	Certified Eligibles as of December '98	Eligibles per 100,000 Population, Age 0-17
Eastern Region	**277**	**73.0**
Albemarle	13	47.9
Duplin-Sampson	12	49.4
Edgecombe-Nash	23	61.0
Halifax	12	76.7
Lenoir	11	74.1
Neuse	31	77.5
Onslow	19	46.0
Pitt	28	91.0
Roanoke-Chowan	7	37.0
Southeastern-Central	54	95.6
Tideland	14	61.7
Wayne	34	120.5
Wilson-Greene	19	87.8
North Central Region	**375**	**93.3**
Alamance-Caswell	28	88.0
Centerpoint	59	68.3
Crossroads	46	93.7
Durham	56	114.9
Guilford	62	69.6
Orange-Person-Chatham	40	101.5
Rockingham	26	125.2
Vance-Granville-Franklin-Warren	58	159.2
South Central Region	**377**	**81.7**
Cumberland	67	77.0
Davidson	37	111.2
Johnston	20	78.1
Lee-Harnett	33	98.6
Randolph	30	101.7
Sandhills	50	103.9
Southeastern Region	72	112.5
Wake	68	48.5
Western Region	**569**	**98.6**
Blue Ridge	59	110.7
Catawba	29	94.3
Cleveland	20	90.4
Foothills	75	143.0
Gaston-Lincoln	61	102.4
Mecklenburg	88	56.0
New River	22	73.8
Piedmont	105	103.4
Rutherford-Polk	34	194.8
Smoky Mountain	55	173.7
Trend	21	99.3
Entire State	**1,598**	**87.8**

3. Age of Willie M. Clients

Most **Willie M.** clients are teenagers. The average age of children in the Program at the end of 1998 was 14.7 years. However, it is very important to understand that there is a wide range in the ages of **Willie M.** clients. The youngest client in 1998 was three years old. The oldest client was age eighteen. While children in the Program generally are removed from the active list at their 18th birthday, some remain as clients past this time if they are near completion of school or other services. TABLE 4 shows the distribution of **Willie M.** clients by their age. It is important to recognize that a large number of **Willie M.** clients are quite young. One-fourth of the Program's clients are 12 years of age or younger.

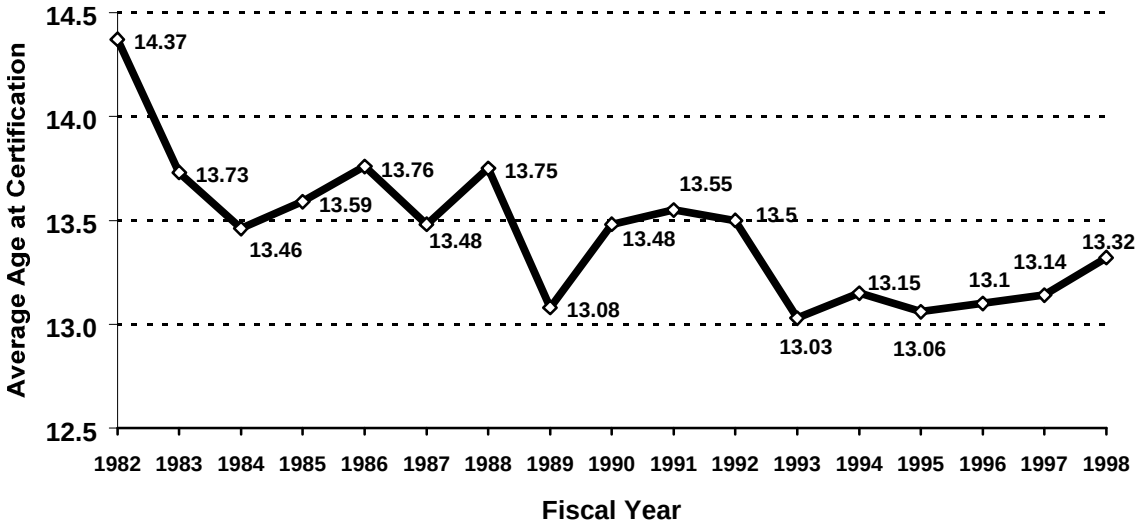
TABLE 4
AGE DISTRIBUTION OF WILLIE M. CHILDREN AS OF DECEMBER 1998

Age	Number	Percent of Total
3	1	0.1
5	3	0.2
6	6	0.4
7	14	0.9
8	30	1.9
9	52	3.3
10	60	3.8
11	84	5.3
12	126	7.9
13	146	9.1
14	192	12.0
15	264	16.5
16	297	18.6
17	295	18.5
18	28	1.8
Total	**1,598**	**100.0%**

While the average age of Program clients has remained relatively stable over time, there is a modest trend in younger children being admitted to the Program. FIGURE 2 shows the average age of newly eligible children for each year the Program has been operating. For the most recent fiscal year, the average age at the time of eligibility determination was 13.32. Over the course of the Program, the average age at certification has ranged from a high of 14.37 years for the first period recorded (FY82) to a more recent low of 13.03 (FY93).

Examination of FIGURE 2 shows a trend with a modest decline in the average age at eligibility for services. Excluding the first year, which was unusual due to factors associated with Program startup, the average age has declined from 13.73 in FY83 to 13.32 in FY98. While this difference is only 0.41 years, the effect on the number of children in the Program is noticeable. For FY83 the average child could have been expected to stay in the Program 4.27 years, while children entering in FY98 would be expected to remain in the Program 4.68 years on average. <u>This small difference would have the effect of increasing the total number of children being served at any given time by approximately ten percent, all other things being equal</u>. The identification of younger children is desirable because it allows for earlier and longer provision of services to clients with, what is hoped, more positive outcomes. It would appear that the downward trend has leveled off at just over 13 years. It seems likely that given the eligibility requirements of violent behavior, the average age should probably not drop significantly further.

Figure 2
Average Age at Certification by Fiscal Year



4. Grade Placement in Public Schools for Willie M. Children

The distribution of **Willie M.** clients across public school grade levels reflects a range from day care up to the 12th grade as would be expected given the wide range of ages for Program clients. The average placement for these children is the eighth grade level. Most clients are either in junior high or high school (see TABLE 5). However, more than one-fourth of the clients are in grade school or below. Ungraded children are clients who are severely impaired and are not classified into a grade level because of the impairment. Grade level placement information was unavailable for two of the children.

TABLE 5
GRADE PLACEMENT AS OF JUNE 15, 1998

Grade Level	Number	Percent of Total
Day Care	4	0.3
Kindergarten	9	0.7
1	16	1.2
2	37	2.7
3	50	3.7
4	54	3.9
5	79	5.8
6	117	8.6
7	181	13.2
8	202	14.8
9	262	19.2
10	180	13.2
11	91	6.6
12	40	2.9
Ungraded	42	3.1
Unavailable	2	0.1
Total	**1,366**	**100.0%**

5. Race of Willie M. Clients

The racial distribution of eligible clients has remained relatively stable over time with the percentage of white members hovering just over half of the total clients in the Program at any given time. At the end of 1998, whites represented 54 percent of all **Willie M.** clients. African-Americans comprised 41 percent of clients, and other ethnic groups represented the remaining 5 percent. In any given year the proportion of newly eligible children will vary but this pattern has been fairly consistent.

6. Gender of Willie M. Clients

The Program has always had an overwhelming predominance of males. At the end of 1998, males comprised 82 percent of the Program client population. This percent has remained relatively stable over time with males generally representing 80 to 85 percent of the total client group in most past years. The preponderance of males is clearly a function of the criteria for eligibility, which include behaviors that are traditionally associated with males, such as externalizing and/or aggressive behaviors.

C. Clinical and Psychosocial Characteristics of **Willie M.** Clients

The single most important fact to understand about **Willie M.** children is that they are a population that has significant emotional, psychological, and social problems and are facing substantial obstacles to normal functioning in society. Indeed, by a variety of different measures, **Willie M.** clients are very *high-risk* children. The needs of Program clients are correspondingly much higher than most other clients and their prognosis much less certain.

1. Clinical Characteristics

It is clear from statewide data that **Willie M.** clients, as a group, have much more severe problems and more seriously impaired functioning than all other North Carolina children who come to area mental health programs for services. We know this because the Division of Mental Health requires that all children served by area mental health programs be assessed for overall global functioning on a standardized clinical instrument. This instrument is the Child and Adolescent Functional Assessment Scale (CAFAS). A 1996 survey of CAFAS scores revealed an average score of severity of 92.7 for **Willie M.** youth, compared to a score of 47.8 for non-**Willie M.** youth who used mental health services in North Carolina.

Assessment of **Willie M.** clients shows that most have multiple psychiatric disorders. Three-fourths of all clients had two or more major psychiatric disorders while more than one-third had three or more disorders. The most prevalent psychiatric diagnoses listed for program clients (counting multiple diagnoses) were:

- Conduct Disorder (51 percent),
- Attention Deficit/Hyperactivity Disorder (45 percent),
- Other Disruptive Behavior Disorders (34 percent),
- Depressive Disorders (19 percent),
- Mental Retardation (19 percent), and
- Post-Traumatic Stress and Related Disorders (17 percent).

Other disorders present in less than 10 percent of program clients included: Substance Abuse Dependency, Bipolar Disorder, Adjustment Disorder, Learning Disorder, Psychotic Disorder, Pervasive Developmental Disorder, Other Anxiety Disorders, and Paraphilias.

Given the psychological problems facing **Willie M.** children, it should not be surprising that they are also classified as having educational handicaps. The Department of Public Instruction collects information about educational handicaps faced by clients. As in previous years, the most common condition is that of Behaviorally/ Emotionally Disabled (BED) with more than three-fifths of all clients being so classified (see TABLE 6). One in every seven (15%) of the **Willie M.** children in public schools was not identified as having any educational handicap.

TABLE 6

EDUCATIONAL HANDICAP CLASSIFICATION AS OF JUNE 15, 1998

Primary Handicapping Condition	Number	Percent of Total
Academically Gifted (AG)	7	0.5
Autistic (AU)	12	0.9
Behaviorally/Emotionally Disabled (BED)	840	61.5
Deaf-Blind (DB)	1	0.1
Educable Mentally Handicapped (EMH)	118	8.7
Hearing Impaired (HI)	11	0.9
Multihandicapped (MU)	8	0.6
Orthopedically Impaired (OI)	2	0.1
Other Health Impaired (OHI)	39	2.9
Preschool-Developmentally Delayed (PD)	2	0.1
Severe/Profound Mentally Handicapped (S/P)	3	0.2
Specific Learning Disabled (SLD)	78	5.7
Speech-Language Impaired (SLI)	2	0.1
Trainable Mentally Handicapped (TMH)	29	2.1
Traumatic Brain Injury (TB)	4	0.3
Visually Impaired (VI)	2	0.1
Not Identified as Handicapped	208	15.2
Total	**1,366**	**100.0%**

2. Psychosocial Risk and Protective Factors

Willie M. clients are *high risk* children. The literature on *high risk* children identifies a number of psychosocial *risk factors* or negative experiences which seem to substantially increase the likelihood of poor life outcomes in realms of mental illness, socioeconomic status, education, vocational instability, criminal justice involvement, and substance abuse. Previous research has found that the presence of four or more risk factors predicts poor outcomes later in life.

However, not all children with multiple risk factors fail to thrive. There is a subgroup of children who possess *protective factors,* or positive experiences, that allow them to avoid poor outcomes later in life. It is these protective factors, and their ability to play a role in improving functioning for at-risk populations of children, that has given rise to the notion of "resiliency." As a concept, resiliency theory has broad acceptance as an explanation of why some children go on to lead fairly normal and productive lives even in the presence of great handicaps and obstacles.

A list of risk factors and protective factors consistently identified in the literature and used for assessment in the **Willie M.** Program is provided in TABLE 7. These factors are evaluated for all **Willie M.** children on the Assessment Outcome Instrument (AOI), and can be divided into several conceptual categories: early developmental factors, skills and competencies, social skills, confident attitudes, family factors, and social support network. A major goal of treatment of *high risk* children is to increase their protective factors or positive experiences to allow them to improve themselves.

TABLE 7
PSYCHOSOCIAL RISK AND PROTECTIVE FACTORS

Risk Factors	Protective Factors
Early Developmental	***Early Developmental***
Premature birth or complications	"Easy temperament"
Fetal drug/alcohol effects	Positive attachment to mother
Long-term absence of caregiver in infancy	Independence as a toddler
Poor infant attachment to mother	***Child Competencies***
Shy temperament	Reasoning and problem solving skills
Siblings within 2 years of child	Good student
Developmental delays	Good reader
"Difficult temperament"	Child perception of competencies
	Extracurricular activities or hobbies
Childhood Disorders	IQ > 100
Repeated aggression	
Delinquency	***Family***
Substance abuse	Lives at home
Chronic medical disorder	Parent(s) consistently employed
Behavioral or emotional problems	Parent(s) with high school degree or better
Low IQ < 70	Other adults or children to help with childcare
Parental Disorders	Regular Involvement in church
Parent with substance abuse	Regular rules, routines, chores in home
Parent with mental disorders	Family discipline with discussion and fairness
Parent with criminality	Positive relationship with parent(s)
Family Stress	Perception of parental warmth
Family on public assistance or Living in poverty	***Child Social Skills***
Separation/divorce/single parent	Gets along with other children
Large family, 5 or more children	Gets along with adults
Frequent family moves	"Likeable" child
	Sense of humor
Experiential	Empathy
Witness to extreme conflict/violence	
Removal of child from home	***Extra-Familial Social Support***
Substantiated neglect	Adult mentor outside family
Physical abuse	Support for child at school
Sexual abuse	Support for child at church
Negative relationship with parent(s)	Support for child from faith
	Support for child from peers
Social Drift	
Academic failure or drop-out	
Negative peer group	***Outlooks and Attitudes***
Teen pregnancy, if female	Internal locus of control as teen

2. (a) Psychosocial Risk Factors

Risk factors are traits, characteristics, innate abilities or deficits, and life experiences that increase the chances of poor outcomes later in life. These are factors that have been identified by researchers over the last twenty-five years in studies over time of child functioning.. As already noted, research has shown that when a child has four or more of these risk factors present, he/she will probably face significant problems later in life. Based on the most recent assessments done of clients, the average **Willie M.** child had 13 risk factors, placing this group of children at extremely high risk for poor life outcomes.

Certification requirements mandate that all **Willie M.** children have the risk factors of behavioral aggression and emotional/mental disorder at the time of initial eligibility. Review of the data reveals that about half of the Program clients had aggressive behavior noted in preschool years, while over 90 percent had developed aggression by the time they reached school age. Listed below is information on the prevalence of the most common risk factors among **Willie M.** clients as a group. This data was developed out of assessments done through February 1999.

The early development of **Willie M.** children is marked by adversity.

- 47.8 percent had neurological impairment or developmental delays

Willie M. children have had significant negative experiences past infancy.

- 82.7 percent have negative relationships with one or both parents
- 81.8 percent have witnessed extreme conflict or violence
- 72.6 percent have been removed from their homes at some point
- 58.6 percent have been documented as being physically abused
- 41.6 percent have experienced substantiated neglect

Most clients come from extremely stressed families.

- 87.1 percent come from single parent, divorced, or separated families
- 84.5 percent of the children come from families living in poverty
- 56.4 percent of the families made frequent moves
- 44.2 percent had siblings born within two years

Most **Willie M.** children have parents with considerable problems themselves.

- 67.7 percent have parents with substance abuse problems
- 61.9 percent have parents with mental disorders
- 44.9 percent have parents with some criminal involvement

Willie M. children experience "social drift" (that is, entering and leaving negative social environments).

- 44.0 percent reported negative peer groups when they became a client
- 42.0 percent are school failures or dropouts

Willie M. children have numerous childhood disorders.

- 99.8 percent have a problem with repeated aggression
- 98.0 percent have behavioral or emotional problems
- 94.3 percent have been in trouble with the law

It is clear that the **Willie M.** clients represent a very troubled group of children. While many of these risk factors cannot be eliminated, focusing on the development of protective factors may allow these troubled children to build a base of stability that provides the capacity to overcome the difficulties they have faced.

2. (b) Psychosocial Protective Factors

Protective factors are specific characteristics of a child or aspects of the child's history, family life, and social support network, which studies have shown confer protection against poor outcomes in high-risk youth. Studies of resiliency in certain high-risk youth suggest that the extent to which a child possesses these positive qualities or experiences offers the possibility of averting common undesirable outcomes, including mental illness, school drop-out, vocational instability, criminal involvement, substance abuse and social dysfunction. Based on the most recent assessments of Program clients, the average **Willie M.** child had 13 protective factors upon entering the Program, but after being in the program for a few years, the average number of protective factors has increased significantly to 20.

Because of the importance of protective factors for fostering resilience or the ability to overcome risk factors, adding protective factors for children has become a key focus of treatment plans with obvious success thus far. This net increase in positive factors should increase the likelihood that these children will overcome or cope with their difficulties. Listed below is information on the current prevalence of the most common protective factors among **Willie M.** clients who have been in the Program at least one year. Information is also provided about the number and nature of added protective factors since these clients started the Program. Examination of the addition of protective factors among **Willie M.** clients reveals marked improvement particularly in the areas of social skills and social support outside the family. It appears that for a substantial group of clients, a variety of positive changes have been made.

Self-perception of competency at some activity is nearly 100 percent, though specific competencies are lower. Importantly, substantial improvements in specific competencies have been made since these children entered the Program.

- 99.1 percent of the **Willie M.** children perceived themselves as being competent at some activity, up 3.8 percent from the start
- 79.9 percent of clients engaged in some hobby or extra-curricular activities, up 35.7 percent from when these clients entered the Program
- 72.4 percent of **Willie M.** clients showed problem-solving skills, up 30.4 percent from the start
- 69.9 percent felt they had an internal locus of control, up 33.3 percent
- 38.7 percent were good readers, up 15.2 percent
- 31.3 percent were judged good students, up 21.3 percent

Family support is generally high for **Willie M.** children with significant increases in all areas since the clients began participation in the Program. Not all of these changes are necessarily a function of participation in the Program but it may be that the Program allows families to make improvements by providing support to the troubled child.

- 94.3 percent of the children feel their parents care, up 15.1 percent
- 93.5 percent had other adults or children to help with childcare, up 10.2 percent from starting the Program
- 88.5 percent had parents who were consistently employed, up 15.4 percent
- 83.9 percent of the children came from families with regular rules, routines, and chores at home, up 28.5 percent
- 82.6 percent of the children had fair discipline at home, up 29.7 percent
- 80.1 percent had parents with a high school degree or better, up 19.8 percent from the children's start in the Program
- 72.7 percent had positive relationships with their parents, up 28.1 percent
- 63.1 percent of the children were in families with regular church involvement, up 20.4 percent

Social skills for **Willie M.** children is an area where clients have made the most progress in adding protective factors since entering the Program.

- 90.4 percent of the children are perceived as "likeable," up 31.1 percent
- 86.5 percent are described as having a sense of humor, up 34.8 percent
- 77.0 percent show ability to get along with adults, up 33.1 percent
- 67.6 percent have shown ability to get along with other children, up 36.9 percent since entering the Program
- 60.9 percent have shown empathy or nurturing behavior, up 37.1 percent

Willie M. clients have also made substantial strides in adding social support outside the child's family that may be linked to improved social skills. Importantly, about one-third of the children added an adult mentor. Studies of resilient youth suggest

that nearly all of those who rose above their risk factors were able to identify some adult mentor figure that was there for them as a refuge and support in times of need.

- 86.9 percent of the children had a positive relationship with someone at school, up 29.5 percent
- 83.3 percent had an adult mentor outside the family, up 31.0 percent
- 62.6 percent had some reliance on inner faith, up 30.2 percent
- 66.0 percent had special support from peers, up 32.6 percent

D. Understanding the Growth in Numbers of **Willie M.** Clients

Mentioned earlier in this section is the observation that the number of **Willie M.** Program clients has been growing, particularly over the last six years. Since 1992, the number of children being served at the end of the calendar year has grown by nearly 50 percent. Given the importance of this growth for the operation and funding of the **Willie M.** Program, it is worth trying to understand why the number of clients has been increasing. Examination of the available information suggests that there are four primary trends at work that may explain most of the growth. Each needs to be considered in turn:

- a growing youth population,
- younger children being found eligible for services,
- greater social problems, and
- greater awareness of the **Willie M.** Program.

The youth population of North Carolina has been growing. Between the beginning of the Program in 1981 and the date of this assessment in 1998, the number of children in the State under eighteen years of age has increased by 12 percent (population estimates derived by the State Planning Office). As the number of children in the State increases over time, there should be an expectation that the number of children being served by the **Willie M.** Program will also increase. Growth in the North Carolina youth population is expected to continue. A further 4 percent increase is anticipated between the years 2000 and 2010. Significantly, the population of North Carolina teenagers, which constitutes three-fourths of the **Willie M.** clients, will be growing much faster. The State population estimates for children aged fourteen to seventeen project a 13 percent increase between the years 2000 and 2010.

A second trend in place is that younger children are being determined eligible as **Willie M.** clients. As discussed earlier, the average age at which children become eligible for services has declined slightly over time. Because all clients remain eligible to at least their eighteenth birthday, the effect has been to increase the total number of children being served. From FY83 to FY98, the average age at eligibility determination has dropped from 13.73 to 13.32. This change alone would have the effect of increasing the total number of **Willie M.** clients by 10 percent.

A third set of trends associated with an increase in the number of **Willie M.** clients is the rise in social problems as diverse as crime and low-weight births. As already noted in the discussion on risk factors, certain experiences tend to increase the likelihood that a child will be at risk for mental illness, violence, and other forms of social dysfunction. Therefore, if certain social problems increase substantially, we would expect to see subsequent increases in the number of at-risk children such as **Willie M.** Program clients. For example, the number of violent crimes in North Carolina increased by 75 percent between 1982 and 1995. Since exposure to violence or extreme conflict is an important risk factor, we might reasonably expect to see noticeable increases in at-risk children. Similarly, premature births or complications at birth is another demonstrated risk factor. The number of low-weight births in North Carolina increased by 29 percent between 1982 and 1995. It is important to understand that even if these negative trends were to stop today, the lingering effects would continue to manifest themselves in children already born so that it might be five to ten years before the complete negative impact would register. A reasonable method for estimating how much these negative social trends would affect the specific numbers of at-risk children is not available, but it is clear that given the magnitude of these trends some significant effect should be expected.

The fourth important trend, which helps explain the growth in the **Willie M.** Program size, is that the Program is receiving more attention and, consequently, more referrals. The Program relies on parents, mental health caseworkers, judges, teachers, and others to refer potential children. Ten to fifteen years ago, the **Willie M.** Program was still relatively new and not well known. With the passage of time more people have become aware of the Program and its potential to help severely at-risk children. Within the last decade the number of new determinations of eligibility for services in a given year has increased by 65 percent. This is despite the fact that eligibility criteria have not substantially changed since the Program began. Therefore, it would appear that the informal network that refers potential candidates to the Program has gotten better at identifying children who meet standards for Program participation.

The overall combination of these four trends would suggest that the increase in **Willie M.** Program clients is due to demographic and referral factors which are outside the control of the Program. Even if the eligibility criteria used since the Program's start, and now established in State Law, remain unchanged, further increases in the Program size are likely. There is insufficient information to predict whether the rate of growth will continue at the pace of the last six years, speed up, or slow down. Those projections cannot be calculated without further monitoring of the trend in Program growth rates.

SECTION THREE

THE **WILLIE M.** SERVICE SYSTEM

This section of the report describes the service system currently in place to meet the needs of **Willie M.** clients. The service system is composed of a State level administrative organization that works in partnership with local level mental health organizations to assure the delivery of appropriate services to all **Willie M.** clients. This partnership is supported with some State-provided services for extremely high-end clients. Noteworthy of comment in this section is:

- a description of the service system and
- an explanation of service coordination and planning for individual children.

A. Description of the Service System

The Department of Health and Human Services (DHHS) and the Department of Public Instruction (DPI) share the responsibility to provide services to the children who are determined eligible as **Willie M.** clients. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) within (DHHS), acts as the *lead agency* by providing direction, leadership, and "vision" to other State and local agencies and individuals, ensuring the provision of appropriate services as stipulated in State law and administrative regulations.

1. State Level Administrative System

Within (DHHS), the State **Willie M.** office operates as a Section within DMH/DD/SAS. The Section performs a myriad of administrative and programmatic functions. Examples of these functions are:

- strategic planning;
- State level program planning;
- development and approval of plans for local systems of service;
- consultation and technical assistance to area programs and contract providers;
- determination of eligible clients;
- budget planning and execution;
- allocation and approval of funding;
- development and provision of specialized training;
- monitoring and evaluation of services at the individual and system level;
- operation and management of two secure non-medical treatment units;
- coordination of services with relevant agencies; and

- contracting with providers or other service systems for the provision of direct services for eligible clients.

The **Willie M.** Section is organized around five mutually supportive Branches. Each Branch specializes in assuring the smooth operation of specific aspects of the overall program. These Branches are:

- The Client Eligibility and Information Branch manages the application and eligibility process and implements formal rules regarding the operation of the application/eligibility determination-based system.
- The Service Management Branch monitors all aspects of service planning and service provision to eligible clients.
- The Information Systems Branch manages the **Willie M.** Information System (WMIS) and continuously strives to enhance its quality.
- The Training Branch develops, administers, coordinates and evaluates training to staff who work directly with clients.
- The Program Evaluation Branch collects and analyzes information regarding the impact of services on the clients as well as monitoring the degree of appropriateness of services that the children receive.

In addition to the functions performed by the Branches, the Section's administrative staff oversees the operation of the **Willie M.** Program. Their responsibilities include:

- working in conjunction with the DPI **Willie M.** Section;
- interacting with other Sections within the Division and local area programs serving **Willie M.** clients;
- supervising the overall functioning of the secure treatment units operated directly by the Section;
- representing the Section, as well as coordinating activities with key external stakeholders such as advocates, parents, judges, court counselors, other community agencies and entities, the General Assembly, the Legislative Study Commission on Mental Health, Developmental Disabilities and Substance Abuse Services, private providers;
- and, handling budgetary and contractual arrangements with area programs and some private providers who work directly with the State level program.

Lastly, the Department of Public Instruction (DPI), is responsible for ensuring that eligible clients receive appropriate educational services as mandated by administrative regulations and/or federal and State laws governing programs for exceptional children. Within the DPI Exceptional Children's Division, the **Willie M.** Section exists as a separate section set aside specifically to help support **Willie M.** students in the Local Educational Agencies (LEAs) statewide.

A major effort underlying all of the work done by the State offices is the **Willie M.** Quality Improvement Process, a series of comprehensive and ongoing efforts developed by DHHS and DPI to ensure that the local service system is able to meet the changing needs of **Willie M.** clients. The quality improvement process entails monitoring activities that are directly connected to improvements in Program operation. The primary thrusts of the monitoring activities are directed at individual children and at the system level with part of the system level monitoring relying on aggregated data of individual children. These monitoring activities in turn are connected to efforts to improve quality in individual service planning, clinical knowledge, practice, system design, and change. Additionally, the **Willie M.** Program has engaged in a series of training efforts designed to improve the quality of the knowledge and skills of the people delivering professional services to clients.

2. Service Delivery System

The provision of direct services is primarily conducted at the local level. The **Willie M.** Section arranges with local area mental health programs to develop, coordinate, and/or deliver services for eligible clients in their catchment areas. Where that is not possible, the **Willie M**. Section contracts with other organizations referred to as "surrogate area programs" or "surrogates" to perform those services. Presently the State arranges services with all but two of the local Area Mental Health Programs and contracts with private providers for services in the remaining catchment areas. Additionally, a limited number of treatment services are operated directly by the State.

2. (a) The Local Service Provider Delivery System

The local area programs or surrogates have the responsibility of developing, directly providing, and/or contracting for a variety of services to meet the diverse needs of their children. The organizational aspects of the local **Willie M**. system are determined at the local level with guidance and approval from the State. Each system varies according to the size and needs of the children; internal organization preferences; geography; and the support by and preferences of the area director, area boards, county commissioners and the community at large.

Historically, area mental health programs have been organized according to disability areas. With the advent of various changes within the mental health field, such as managed care programs like Carolina Alternatives, a number of area programs have moved to a cross-disability service delivery system, separated by functions rather than disability. These alternative methods of organizing and developing staff are supported by the State as long as Program clients are served appropriately.

It is crucial that the **Willie M.** system assures the availability of a balance of services in every local system. Certain core services are always included in the service array. These core services include: case management, clinical assessment

and treatment, crisis back-up and stabilization, para-professional/in-home support services, educational services, alternative family living homes and other residential services such as: group residential treatment, supervised living, secure non-medical treatment, and inpatient hospital, or at least access to these services.

Over the past five fiscal years, one of the **Willie M.** Section's major objectives has been the establishment of core mental health services within each area program. Some of these services are provided directly by the local area mental health program and others are available through other service providers such as the Local Educational Agencies or Department of Social Services. Each area mental health agency or "surrogate" organizes and structures its **Willie M.** Program differently and is reimbursed by the State for the services actually provided. A local area program may either provide all or some of the services directly, or contract with private providers, and oversee the provision of any contracted services. If needed services do not exist within an area, the local area program develops those services within its community or secures an appropriate alternative, such as using established services in another area program or those provided by a private agency.

Willie M. services include housing, education, counseling, medical treatment, vocational training, and other social and human services (see FIGURE 3 - **Willie M.** System of Services). A Case Manager assesses the child's needs and coordinates appropriate services from a wide range of providers, including area mental health centers, local school districts, or community-based private treatment specialists. The **Willie M.** system of services is organized around five service categories:

- **Clinical and Staff Services** - These are services, including case management, provided for a child by individual professional or paraprofessional staff in accordance with the child's individual treatment and habilitation plan. In-home services can include crisis intervention, parent training, and/or counseling for the child and other family members. Outpatient treatment services offer ways to improve or stabilize the child's family environment, to minimize the necessity for out-of-home placement, and to increase the child's family's understanding of how they can affect the child and family's developmental growth.

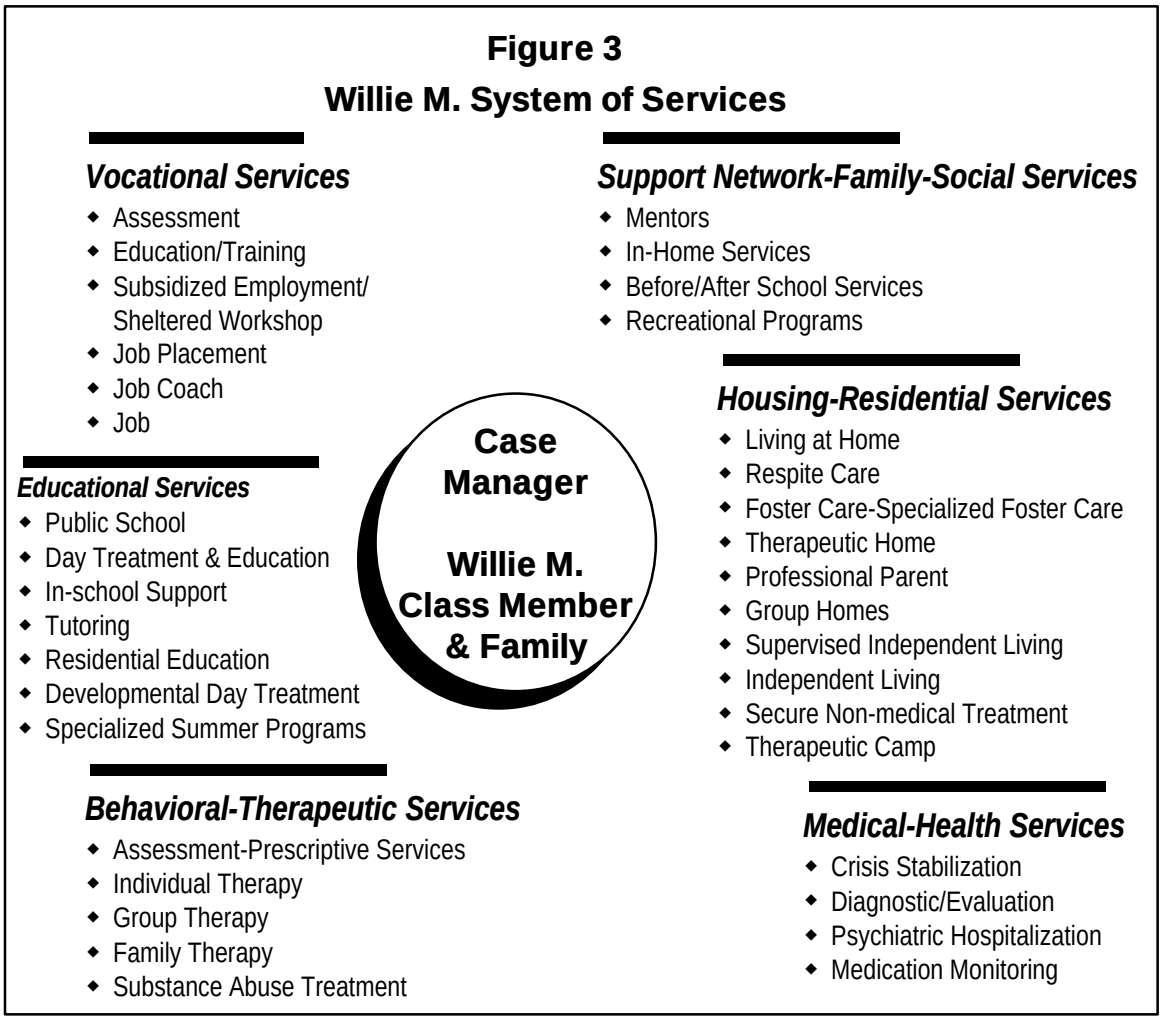
- **Educational Services** - The majority of **Willie M.** children attend regular or self-contained classes in public schools. Others require more specialized educational services, such as combined day treatment/education, developmental day care, in-home or inpatient education or, a State-operated program. Related services include before- and after-school programs, as well as summer camps.

- **Residential Services** - There are a broad range of options for children who cannot live in their own homes. They range from structured, individual and group environments to independent living. Some **Willie M.** clients live in

homes with specially trained staff who serve as "parent substitutes." Others who live at home are best served through respite care providers.

Figure 3

Willie M. System of Services



- **Vocational Services** - Older eligible clients (ages 16-18) may learn pre-vocational and vocational skills, including job interviewing, work values, social skills, and job skills. Some **Willie M.** clients have supervised work experiences - such as sheltered workshop placements, apprenticeships, and part-time jobs - that help prepare them for independent employment as adults.

- **Inpatient or Secure Services -** Some clients are best supported through short- or long-term hospitalization for diagnostic testing, medical care, and psychiatric treatment. Such placements include crisis stabilization when a child is undergoing a psychiatric or emotional episode too severe to be handled in the home. Treatment in secure (locked) settings for children who cannot be treated safely or effectively in more normalized community services is also provided.

The type and location of services available are listed in APPENDIX 1. This Appendix notes the area programs where particular services were given to eligible clients during Fiscal Year 1997-98.

2.(b) State Level Services Contracts

Because of the substantial infrastructure and community networks available through local area programs, it is the policy and preference of the **Willie M.** Section to provide most services through local mental health agencies except in extraordinary circumstances. When exceptional service provisions are required, the State contracts with others, including private providers, for these programs. Those in current operation are:

- **Carolina Treatment Services** is under contract with the State to operate a five-bed high management group home in Guilford County.
- **NOVA-HRS, Inc.** operates eight three-bed supervised residential treatment facilities along with a day treatment program with capacity for 24 students in Wayne County. This program serves clients from throughout the State with preference given to those children from the eastern portion of the State.
- A contract with **Lutheran Family Services** (LFS) was established in Fiscal Year 92-93 to provide services to **Willie M.** clients in Johnston County.
- In Fiscal Year 94-95, the State entered into a contract with the **Institute for Family Centered Services** (IFCS) to provide services for clients from the Albemarle area.

2. (c) State Level Provided Services

In addition to the local provider delivery system, there are a limited number of services operated directly by the State. These are:

- **Butner Adolescent Treatment Center (BATC)**, a secure non-medical treatment facility serving 12 **Willie M.** clients who require a locked environment in order to participate in appropriate services. The Center opened in February 1992 and operates in four wards of John Umstead Hospital. A school program is included in the program structure.

- **Oakview Supervised Apartment Program** also located on the Umstead campus. Oakview was opened by the State in October 1993 and consists of five apartments capable of housing up to 12 clients. Oakview has 24-hour staffing and provides a transitional residential program for clients leaving secure treatment, institutions, training school or other settings and who may not be ready for full re-integration back into the community. Clients served at Oakview receive their education at BATC, local schools, or adult education programs through the local community college. Vocational

programming and training are key competencies for older eligible clients. The clients in this Program remain under a North Carolina General Statute122C mental health commitment.

- **Eastern Adolescent Treatment Program (EATP)**, a program modeled after BATC. EATP opened in September 1995 at the North Carolina Special Care Center in Wilson. EATP is an 8-bed, secure non-medical treatment facility. The **North Carolina Special Care Center**, part of the State system of services, administers this Program.

B. Service Coordination and Planning for Individual Clients

Meeting the needs of the individual child continues to be the primary aim of the **Willie M.** Program. Accordingly, each client has an individual plan developed to address specific treatment issues and a Case Manager who coordinates the range of services necessary to meet the child's needs.

1. The Individualized Planning Concept

Individualized planning and care are the heart of the **Willie M.** service delivery system. Planning for each client's treatment/habilitation is accomplished under the direction of a Case Manager through the development of an individualized Treatment/Habilitation Plan (T/HP). Each child is required to have a T/HP that is reviewed whenever the individual client's needs and/or circumstances change or at a minimum, annually.

Willie M. Case Mangers have the primary responsibility for seeing that T/HPs for their clients are completed, monitored, and updated as necessary. However, they do not do this planning and monitoring alone. They work as a team with the client and the client's family, clinicians, educators, representatives from other agencies, court officials, and others to develop the client's T/HP. The planning process focuses on the strengths of the child, his or her preferences, and the child's needs to develop a set of desired outcomes based on the individual child's situation. Using the desired outcomes, a set of strategies and interventions is put together to provide a clear set of actions and steps to a client's team members to assist the client in achieving his goals. The plan, along with assigned responsibilities, is used by the Case Manager to monitor what the child is doing and act as an advocate over time within and outside the service system to ensure that client's needs are being met and progress is being made to the individual client's goals.

2. Case Management in the "System of Services"

Case management is the core mechanism around which the complex system of services operates. Case Managers are pivotal to the successful operation of **Willie M.** services. An individual Case Manager is assigned to every **Willie M.** client. This individual assumes the lead role in coordinating the child's treatment and other services. Their responsibilities include planning, coordinating, documenting, and monitoring services provided to a child and his/her family/guardian or custodian as well as serving as an agency advocate for the child, particularly with regards to service development and acquisition.

Area programs typically also have an individual person designated as the Coordinator of **Willie M.** services in the catchment area. This person acts as the liaison to the State **Willie M.** Section and is responsible for managing and monitoring the local service system. This person may or may not have other responsibilities within the local agency system.

The framework for delivery of **Willie M.** services is the "system of services" model. This schema calls for a broad array of services to be used in the treatment of the **Willie M.** population. Reliance on a holistic approach to treatment and service delivery allows the Case Manager to include recognition of the medical, psychological, social, behavioral, educational, vocational, residential and legal aspects of a child's life. **Willie M.** clients have multiple needs that span a variety of services, agencies, community arenas, and systems. Case Managers work with their local service systems to effectively respond to the changing needs of the clients for whom they are jointly responsible.

SECTION 4

EXPENDITURES FOR THE **WILLIE M.** PROGRAM

This section of the report describes the costs of providing services to **Willie M.** clients. The section provides information on:

- **Willie M.** Program funding and expenditures,
- average expenditures for **Willie M.** children,
- waivers of cost rules, and
- other State funds spent on **Willie M.** children.

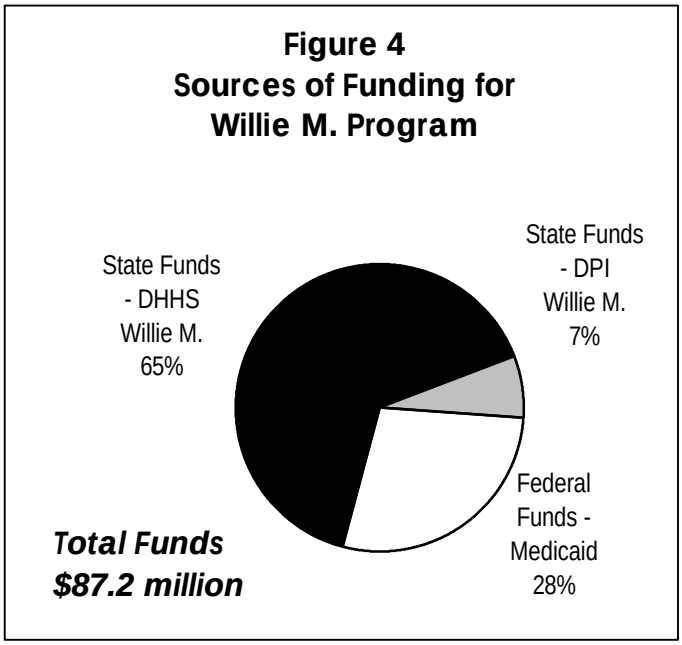
A. **Willie M.** Program Funding and Expenditures

In Fiscal Year 1997-1998, over $87.2 million was spent in the **Willie M.** Program. This includes State-appropriated funds and federal Medicaid dollars. The totals for the Program, however, do not include other State expenditures on children in the **Willie M.** Program that were not part of the Program's operation. Details related to this latter category of spending are presented at the end of this section.

1. Sources of Funding for the Willie M. Program

Of the total $87.2 million spent on the **Willie M.** Program in FY97-98, nearly three-fourths, or 72 percent, was from State appropriations (see FIGURE 4). The majority of funds, $56.8 million, or 65 percent, were State appropriations earmarked for the **Willie M.** Program through the Department of Health and Human Services (DHHS). An additional $6.1 million, seven percent of the total, came from State funds appropriated to the Department of Public Instruction (DPI) as a portion of the **Willie M.** Program. Federal Medicaid funds accounted for $24.3 million or just over one-fourth of Program funds. This large proportion of federal funds reflects strong efforts in the last few years to identify **Willie M.** children who qualify for Medicaid in order to further extend State resources. Much of the overall Program expenditure growth has been achieved by greater use of federal dollars.

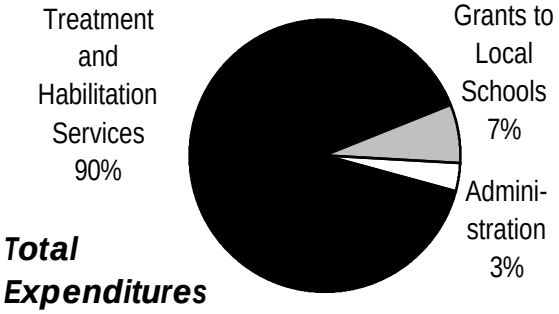
Figure 4
Sources of Funding for Willie M. Program



2. Expenditure Categories for the Willie M. Program

Of the total expenditures in FY97-98, $78.3 million, 90 percent, was for DHHS treatment and habilitation services such as case management and residential services appropriations (see FIGURE **5**). DPI money, $6.1 million, accounted for seven percent of the total and was distributed in the form of grants to local school districts for services provided to **Willie M.** children. Administrative costs for the Program totaled $2.8 million, three percent of the total, with one-third of that amount coming from federal Medicaid dollars.

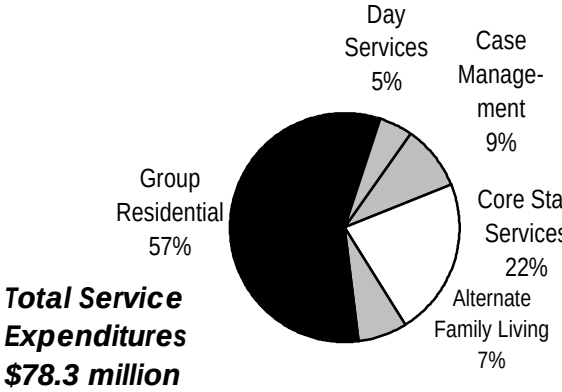
Figure 5
Major Expenditure Categories for Willie M. Program



2 (a). Treatment and Habilitation Services Expenditures

Treatment and habilitation services are the largest category of the **Willie M.** Program expenditures. During FY97-98, these services cost a total of $78.3 million, an increase of six percent from the prior fiscal year. This total includes State expenditures and federal Medicaid dollars. Analysis of the data shows that the increase in costs was due to an increase in the number of Program clients and not changes in rates paid for services.

Figure 6
Treatment and Habilitation Services for Willie M. Program



Treatment and Habilitation Services Expenditures can be helpfully divided into five functional subcategories: case management, core staff services, alternate family living, group residential, and day services (see FIGURE 6). The relative proportions spent on the subcategories match the percents from the prior fiscal year. Residential services - group residential and alternate family living - are the major expense categories. They represent nearly two-thirds of

Willie M. Program service expenditures. Group residential services represent the largest set of costs and are used for children who require more intensive monitoring or who cannot live at home. For FY97-98, group residential expenditures represented 57 percent of total treatment and habilitation expenses. Alternate Family Living represents additional residential services including respite care, foster care, and other alternative family living arrangements and totaled 7 percent of all of the treatment and habilitation costs. Core staff services represent both outpatient treatments such as counseling and paraprofessional services designed to help the child meet his/her particular needs.

As described in the Service Delivery System section, the **Willie M.** system of services is provided through local area mental health programs. The actual costs of providing treatment and habilitation services vary by program and by the providers that are used. Further detail about expenditures by service category and the average costs of providing the services in Fiscal Year 1997-98 can be found in TABLE 8. The expenditures in the table include state appropriations and Medicaid funds. The average unit cost for each service is simply the total expenditures divided by the total number of units provided. As can be seen in TABLE 8, the cost for particular services can vary with the highest payment frequently being two to four times higher than the lowest payment. However, most payments tend to be near the average. Unless granted cost waivers, all providers are required to stay within State rates.

Comparisons of average payments paid in FY97-98 with the prior fiscal year show little change overall in rates. On balance the effect of average rate changes actually declined slightly but by less than half of one percent. The increase in program service expenditures was due to an increased number of children being served and more units of service being provided. Rates being paid increased for some services but declined for others. Services showing substantial increases in average payments included Outpatient Treatment, Foster Care, and Inpatient Hospitalization. However, a number of services had substantially lower average payments in FY97-98 including HRI-Periodic, Group Living Specialized, Wilderness Camps, Day Treatment, Vocational Placement, and Before/After School Programs.

2 (b) Educational Expenditures

The Department of Public Instruction **Willie M.** funds are designated as "add-on" funds. The Local Educational Agency (LEA) requests funding to supplement and strengthen services for the most difficult to educate **Willie M.** clients. Initial allocations are made in August, with adjustments made throughout the year. The State's total allocation was $6,060,683, an increase of eight percent over the prior fiscal year allocation of $5,628,927. The allocations by LEA are shown in TABLE 9.

Along with the allocations for Fiscal Year 1997-98, TABLE 9 also shows the number of children served. For LEAs that show students but no allotment, no funds were requested. LEAs that show allotments but no students actually had students for a period but none at the time when the count of students was taken.

TABLE 8

WILLIE M. PROGRAM SERVICE EXPENDITURES AND UNIT COSTS FOR FISCAL YEAR 1997-98

Service Component	Number of Providers	Total Expenses	Total Units	Average Payment	Range of Payments	
					Minimum Payment	Maximum Payment
Case Management		**$7,188,152**				
Case Management	41	$4,244,877	101,519	$41.81	$32.11	$48.70
Case Mgmt Support	41	$2,943,275	70,916	$41.50	$31.40	$48.70
Core Staff Services		**$17,411,121**				
Outpatient Treatment	62	$3,885,912	81,768	$47.52	$4.22	$150.00
Outpatient Support	46	$2,051,563	47,714	$43.00	$29.53	$90.91
HRI Periodic	28	$3,319,426	75,269	$44.10	$21.85	$51.64
HRI Periodic Support	13	$441,212	9,212	$47.90	$43.97	$51.64
Para-Professional	50	$6,570,051	299,279	$21.95	$12.40	$30.92
Para-Profess. Support	35	$1,142,957	49,755	$22.97	$8.01	$30.92
Alternate Family Living		**$5,461,434**				
Respite Care	31	$277,228	3,885	$71.36	$66.40	$278.40
Foster Care	3	$22,796	262	$87.01	$84.97	$87.50
Alternative Family	51	$5,161,410	62,387	$82.73	$67.57	$130.00
Group Residential		**$44,445,939**				
Group Home- Moderate	5	$380,616	1,812	$210.05	$162.26	$231.10
Group Home-High	58	$15,616,040	68,985	$226.37	$57.00	$287.81
Group Living-Secure	4	$4,674,059	12,486	$374.34	$246.95	$487.75
Group Living-Special	5	$607,901	4,342	$140.00	$50.77	$178.20
Crisis Stabilization	5	$55,544	248	$223.97	$70.32	$341.92
Residential Treatment	57	$19,048,506	68,536	$277.93	$93.70	$399.86
Wilderness Camps	6	$1,755,181	9,532	$184.14	$135.00	$300.00
Inpatient Hospital	23	$2,308,092	7,751	$297.78	$91.11	$509.00
Day Services		**$3,772,950**				
Day Treatment	29	$3,489,678	157,060	$22.22	$12.99	$35.61
Vocational Education	3	$3,161	467	$6.77	$3.15	$7.53
Vocational Placement	8	$137,905	13,014	$10.60	$6.57	$11.98
Before/After School	7	$61,773	4,488	$13.76	$13.70	$14.04
Special Summer Program	10	$80,433	9,570	$8.40	$5.05	$8.96
TOTAL		**$78,279,596**				

TABLE 9

DEPARTMENT OF PUBLIC INSTRUCTION WILLIE M. ALLOCATIONS TO LOCAL EDUCATIONAL AUTHORITIES, FISCAL YEAR 1997-98

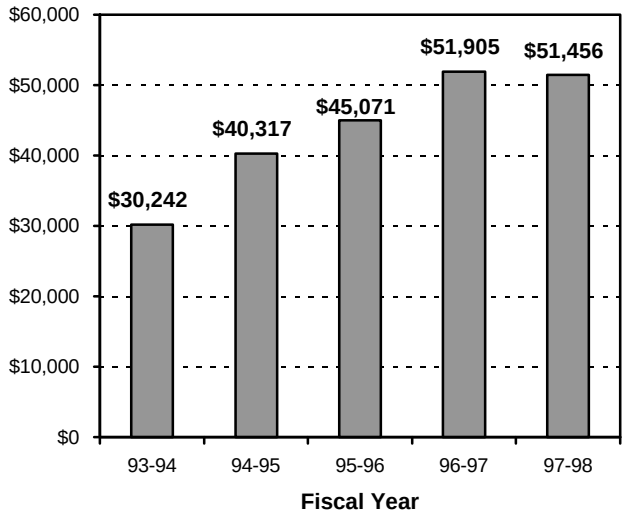
LEA	Allotment	Students	LEA	Allotment	Students

Alamance	110,375	19	Johnston	132,561	30
Alexander	48,155	6	Lee	48,833	13
Alleghany	18,440	1	Lenoir	109,000	33
Anson	0	4	Lincoln	65,224	8
Avery	13,013	7	Macon	17,400	3
Beaufort	36,459	6	Madison	0	1
Bladen	52,322	4	Martin	2,614	2
Brunswick	36,370	7	McDowell	61,084	11
Buncombe	168,118	32	Charlotte-Mecklenburg	423,111	96
Asheville City	138,792	12	Mitchell	1,100	1
Burke	103,874	13	Montgomery	0	1
Cabarrus	88,398	10	Moore	60,081	18
Kannapolis City	0	5	Nash	111,351	12
Caldwell	171,610	27	New Hanover	64,394	26
Camden	25,411	4	Northampton	0	3
Carteret	19,243	4	Onslow	116,995	15
Catawba	14,354	5	Orange	66,703	5
Hickory City	6,729	5	Chapel Hill/Carrboro City	0	3
Newton-Conover City	0	1	Pamlico	18,206	5
Chatham	0	2	Elizabeth City/Pasquotank	52,132	9
Cherokee	26,944	5	Pender	8,840	4
Cleveland	66,427	11	Perquimans	26,318	1
Shelby City	0	4	Person	87,648	15
Columbus	17,306	3	Pitt	145,922	25
Whiteville City	33,642	3	Polk	13,791	1
Craven	49,421	11	Randolph	48,111	7
Cumberland	379,550	108	Asheboro City	31,748	10
Currituck	0	1	Richmond	15,551	5
Dare	35,695	3	Robeson	183,666	58
Davidson	33,173	12	Rockingham	92,517	15
Thomasville City	0	2	Rowan-Salisbury	68,165	15
Lexington City	83,062	9	Rutherford	17,043	13
Davie	40,803	5	Sampson	7,022	2
Duplin	32,820	7	Clinton City	0	5
Durham	155,567	46	Scotland	35,528	5
Edgecombe	36,654	7	Stanly	20,675	7
Winston-Salem/Forsyth	133,969	25	Stokes	0	1
Franklin	6,459	7	Surry	11,600	8
Gaston	135,435	33	Elkin City	298	1
Graham	33,882	6	Mount Airy City	0	2
Granville	28,077	16	Swain	18,002	2
Guilford	310,576	77	Transylvania	16,106	3
Halifax	17,215	9	Union	172,897	50
Weldon City	0	1	Vance	84,271	23
Harnett	0	12	Wake	201,645	59
Haywood	23,583	9	Warren	24,603	4
Henderson	117,457	12	Watauga	46,717	5
Hertford	32,661	3	Wayne	208,288	52
Hoke	29,070	12	Wilkes	45,918	5
Iredell-Statesville	21,255	5	Wilson	51,859	14
Mooresville City	4,869	0	Yadkin	36,198	11
Jackson	51,278	10	Yancey	434	0
Total for State	**$6,060,683**	**1,366**			

B. Average Treatment Costs for **Willie M.** Children

Using the average daily caseload of clients served, the adjusted average cost per client was $51,456 in FY97-98. During FY97-98, the **Willie M.** Program served a total of 1,929 children, but the average daily caseload was 1,521.3 clients. Many of the **Willie M.** children served in a year are only eligible for service part of the time because they either were newly eligible for services or "aged out" when they turned 18 and were no longer receiving services. FIGURE 7 shows the historical trend for the last five fiscal years using the adjusted average which accounts for the time clients were actually eligible for services. As can be seen, the average cost per client actually declined slightly (one percent) in FY97-98. This follows a number of years where average cost per client increased substantially each year.

Figure 7
Average Cost per Eligible Client Over Time for Treatment and Habilitation Services



In prior years the average cost for treatment services for **Willie M.** clients was calculated by dividing total treatment and habilitation costs by the total number of clients served in the year. However, since many of the clients served in a given year are not eligible for services for the entire fiscal year, this produces a lower average that is not representative for the clients being served throughout the year. To provide a more accurate assessment of what an average **Willie M.** client costs, this year, treatment costs are divided by the average daily caseload for the **Willie M.** Program. This calculation counts only the days clients were actually eligible for services. This average cost per child includes both State and federal Medicaid dollars. Using the prior method of calculation, the average cost per client would be $40,580, substantially less. The old method of calculating average costs per client also shows a slight decline over the last fiscal year.

As in previous years, there is a wide variation in actual costs per client served. While the cost of serving most of these at-risk children is not high, a sizable number of clients are very expensive to treat. TABLE 10 divides the children into five groups according to the total amount of treatment and habilitation expenditures made for the fiscal year. This table does not include educational expenditures because the DPI grants are made to the local education agencies for the provision of supplemental services which are not all specific to individual children. The first group of children in TABLE 10 are those for whom total program expenditures totaled less than $25,000 or less than half of the adjusted statewide average. This group of children represented

46 percent of the kids served in FY97-98. The average cost of serving these children was $6,562. This amount is low in that it reflects a number of clients who received services for only part of the year. The first three categories of clients in TABLE 10 represent all those children whose cost was below 150 percent of the statewide average cost, a legislatively defined standard for defining high-cost cases. Thus, 79 percent of the total number of children served were below the 150 percent standard or $75,000. This distribution is very similar to the prior fiscal years.

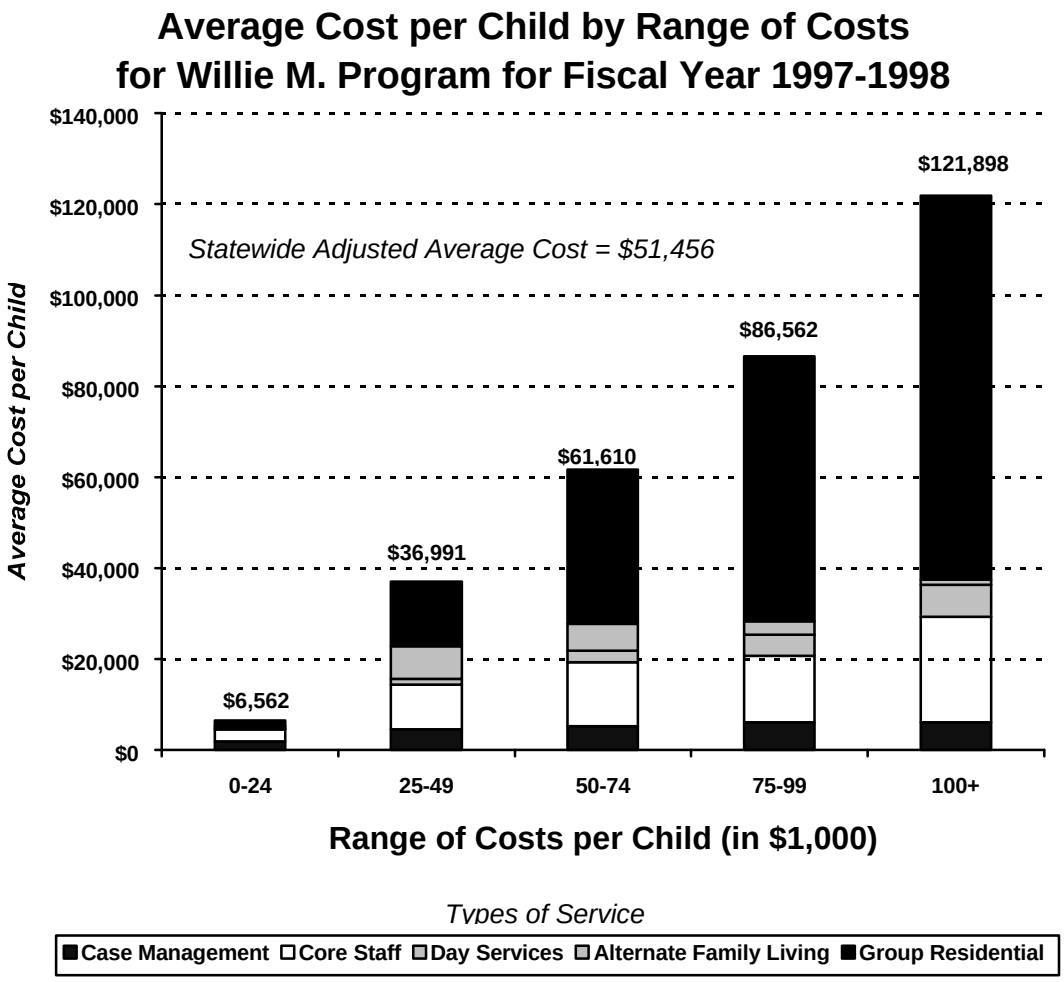
TABLE 10

COSTS OF TREATMENT AND HABILITATION SERVICES FOR WILLIE M. CLIENTS FOR FISCAL YEAR 1997-98

Range of Costs (in $1,000)	Number Of Children	Percent of All Children	Total Expenditures (in millions)	Percent of All Expenditures	Average Cost per Child
0-24	894	46.3%	$ 5.9	7.5%	$6,562
24-49	369	19.1%	$13.6	17.4%	$36,991
50-74	257	13.3%	$15.8	20.2%	$61,610
75-99	196	10.2%	$17.0	21.7%	$86,562
100 +	213	11.0%	$26.0	33.2%	$121,898
State Total	**1,929**	**100.0%**	**$78.3**	**100.0%**	**$40,580**
State Average Adjusted for Time in Program	**1,521.3 (average caseload)**		**$78.3**		**$51,456**

The large differences in average cost per child are primarily a function of the degree to which a child requires residential services as part of his/her treatment. FIGURE 8 shows bars representing each of the five groups of children by range of costs found in TABLE 10. The graph shows the average amount spent by type of service for each of these categories. The first group, whose total costs were less than $25,000, used small amounts of all services. It is important to remember that this group includes many children who only received services for part of the year. For the other four categories of children in FIGURE 8, the most important difference between them is the amount spent on group residential services. While there are variations in the amount of the other types of services, it is the level of group residential services used that most accounts for why certain children become high-cost clients. Residential services are more intensive and more expensive than community support services. The children who require group residential services have higher needs, particularly intensive monitoring. This high-cost group also uses core staff and day services at more than twice the State average. This higher level of supervision is needed for the child, the child's family, and the community. Thus, requirements for safety and supervision of high-risk children are primary determinants of cost in the program. It is critical to realize that these particularly high-risk and thus high-cost children have such pressing needs that even if the

Figure 8



Willie M. Program were not in place, these children would still require State expenditures through psychiatric hospitals and juvenile or adult correctional facilities.

C. Waivers of Departmental Cost Rules

Waivers of DHHS rules are occasionally granted in order to assure the continued availability of services to **Willie M.** clients. The annual Appropriations Act requires the Department to report on waivers granted during the year. There are two types of waivers granted; each allows providers to be paid more than would otherwise be allowed under the Unit Cost Reimbursement System (UCRS) for the **Willie M.** Program. The two types are a maximum rate waiver and a utilization requirement waiver.

- A maximum rate waiver allows the provider to charge a unit cost rate higher than the published maximum allowable rate in the UCRS Plan. These are typically situations where local staff salaries are higher due to greater expertise or child-specific services requiring more intense or specialized care that is more costly.

- A utilization requirement waiver lets a provider earn reimbursement where some anomaly in reporting or payment causes earnings to be too low for an area program. Examples include service units that were initially not properly reported resulting in underpayment or unexpected empty beds in a treatment unit raising the average cost per bed being used.

In either case, only the Division Director may approve a waiver in extraordinary situations. The discussion below briefly describes both types of waivers that were approved during FY97-98. Generally, these waivers are for prior fiscal years.

1. Maximum Rate Waivers

Fourteen (14) maximum rate waivers were granted during FY97-98 (see APPENDIX 2 for more detail). This figure is down from twenty-one waivers approved in FY96-97. Of these maximum rate waivers:

- 13 were for residential services and
  - 3 for Group Home - High Management
  - 1 for Group Home – Moderate Management
  - 1 for Respite Services
  - 8 for Group Living - Special
- 1 was for Day Treatment.

The definition for Group Living – Special was used to capture information on a variety of residential services. As a result, this service category did not lend itself to a rate setting of comparable programs. Rates were actually negotiated with individual providers. These eight waivers, upon year-end analysis, were above the stated maximum rate of $92.20 in the budget manual. This was an error on the part of the Section in not establishing this as a *Negotiated Rate* category. The area programs and

their respective contract agencies providing this service are identified in APPENDIX 2. Three providers are included in this list: Thompson Children's Home (also categorized in the WMIS as Thompson's Episcopal), Alexander's Children's Home, and Elon Children's Home.

Mecklenburg Area Program received waivers for two Group Living categories, Moderate and High Management. The rationale for both waivers was identical: higher cost of living, longer tenured staff resulting in higher longevity and performance increases, and the addition of part of a psychologist position to support each service objective.

The VGFW Area Program received three waivers; two for residential services and one for day treatment services. The accepted justification for the respite service waiver was that the population served is younger and more violent than in recent history and increasing pressure and competition for higher rates to retain qualified providers. The waiver for the Group Living – High Management facility called VGFW Group Home and the waiver for Day Treatment were granted for similar reasons. The population served is younger and more violent with an increase in sexually aggressive clients resulting in a more intense staffing ratio. Also, due to the longevity of staff, salary adjustments were approved as well.

The Edgecombe-Nash area program received one maximum rate waiver for Upstream Group Home, a Group Living - High Management facility. This facility had historically been under utilized as a six bed facility. Approval was granted to change the model from a six-bed Group Living - High Management program to a three bed Residential Treatment facility effective November 1997. The Group Living - High Management rate was approved at actual utilization and resulted in a rate that was above the maximum rate. The new model, Residential Treatment, was budgeted at the Statewide Average Rate.

2. Utilization Requirement and Earnings Waivers

Fourteen utilization waivers were approved by the Division Director during FY97-98. These waivers cover multiple years from FY93-94 through FY96-97 resulting in a total waiver amount of $842,161. Although several other waivers have been approved since the end of the fiscal year, the reporting cutoff date for this report was June 30, 1998. Any waiver requests approved by the Division Director after this date will be reflected in next year's report. These waivers and their amounts may not match the fiscal year the waiver was paid. The waivers granted during FY97-98, listed by area program, type of service, cost, and relevant fiscal year include:

- Cleveland: Miscellaneous Services Reported but Not Paid for FY93-94 ($11,733)
- Carolina Treatment Services: (State Level Contract) Group Living – High Management for FY96-97 ($28,529)

- Guilford: Vision Youth Home for FY96-97 ($10,846); Day Treatment for FY96-97 ($41,905)
- Halifax: Wood House for FY94-95 ($29,395); Wood House for FY96-97 ($61,853)
- Mecklenburg: The Willows (Alternate Family Living) for FY96-97 ($112,240), Increases in Fund Reserves for Group Living and for Client Specific Allocations for FY96-97 ($48,125), and Over Expenditure in Core Services for FY96-97 ($89,328)
- Piedmont: Miscellaneous Services for FY95-96 ($261,896)
- Surry-Yadkin: Miscellaneous Services for FY94-95 ($51,260); Miscellaneous Services for FY94-95 ($22,948)
- Tideland: Vehicle Payment Discrepancy for FY94-95 ($1,871); Tideland House (Group Living – High Management) for FY96-97 ($17,060)

D. Other State Funds Expended on **Willie M.** Clients

Willie M. Program clients are entitled to all services and resources normally entitled by any other child in North Carolina. Assaultive Children's Funds are to be considered the last dollars spent. Once these other funds have been utilized, **Willie M.** Program funds are to be spent on services for the clients. More aggressive efforts are being undertaken by area programs in response to urging by the **Willie M.** Section to ensure utilization of other funding, including non-state funding such as Medicaid and Supplemental Security Income (SSI).

These other state expenditures are not directly controlled or tracked through the **Willie M.** program. Indeed, most of these expenditures would be incurred even if the program were eliminated since they relate to other entitlements or requirements. For example, State education funds for the regular student allocation and for exceptional children are not distributed based on status in the **Willie M.** Program. While the program does not control these other State funds, it is important to understand that there can be an indirect influence. If the **Willie M.** Program is successful at keeping children in school, this will increase State educational fund expenditures. However, by keeping the children out of training schools, correctional facilities, and/or psychiatric hospitals, it is believed that the **Willie M.** Program effectively reduces other

TABLE 11

OTHER STATE FUNDS SPENT ON WILLIE M. CHILDREN FOR FY 97-98

Source of Funds	Amount
Medicaid (State share for all services not in State Facilities)	$13,012,639
State DMH/DD/SAS Facilities (Including Medicaid)	$1,472,973
Training Schools	$1,661,347
Detention Centers	$158,358
N.C. School for the Deaf	$0.0
State Education Funds	$7,220,365
TOTAL OTHER STATE FUNDS	$23,525,682

State expenditures. The net effect cannot be estimated here. A summary of these other State funds can be found in TABLE 11. The total of all these other State funds expended, in FY 1997-98 was estimated at $23.5 million. APPENDIX 3 provides further details about the contribution of each of these State sources.

SECTION 5

PROGRESS AND FUNCTIONING OF **WILLIE M.** CLIENTS

This section of the report describes the level of functioning of current **Willie M.** children and the progress they have made. Information is provided about:

- overall patterns of progress in outcomes and
- functioning and progress in seven different areas.

A. Overall Patterns of Progress for **Willie M.** Clients

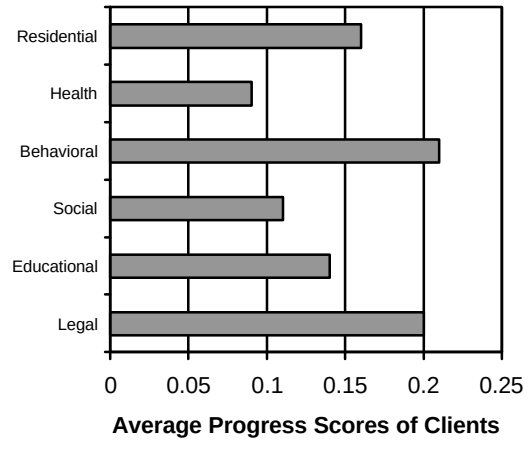
The effort to assess functioning and progress on an ongoing basis for the **Willie M.** clients is unmatched either in the State or around the nation. Over the last few years, the **Willie M.** Program, with the support of the General Assembly, has invested in the development and implementation of an extensive system to monitor outcomes and progress of **Willie M.** children. An extensive amount of information is being collected at various times by using various survey instruments. The **Willie M.** Program continues to move forward in both the scope and sophistication of use of collected information to monitor and improve services provided to Program clients.

When viewed from a broad perspective, several key findings stand out with respect to the patterns of progress being made by **Willie M.** clients as a group.

- **<u>Progress is Evident in All Critical Areas</u>**

The **Willie M.** Program assesses functioning and progress in key domains or areas. Based on the available assessments, in all of the key areas, some progress has been made between the clients' initial assessments and their most recent ones for the Program clients as a group. As can be seen in FIGURE 9, the areas where progress is most evident are in the residential, behavioral, and legal domains. Assessment questions have possible answers ranging from 1 to 5, with 5 indicating no problems and 1 being serious problems. The measures of progress reported here are averages for all program clients of the differences between their most recent assessment scores and their initial assessments. Thus, if on the first assessment, the average score was 3.5 and on the most recent assessment the

Figure 9
Key Areas of Progress



average score was 3.7, the group average measure of progress would be 0.2. A positive number indicates a higher score on average at the most recent assessment and thus progress. It is possible to have negative numbers which would indicate regression, though for the group of clients as a whole, there were no negative numbers on these overall measures. Even though the amount of progress was not striking in some areas, none showed a decline. Even just stabilizing these children is an important achievement, as many would likely continue to decline in functioning without significant intervention. But progress is being made as clients are being moved to less restrictive living situations, violent or aggressive behavior declines with participation in the Program, contact with legal agencies declines, and more children are remaining in school.

- **The Most Challenged Clients Derive the Greatest Benefit**

Those clients who have the lowest assessments when they enter the program make the most progress. In every area of assessment, those children making the most progress began the program with the worst problems. These were the clients most likely to be hurting others or themselves, living in locked facilities, with no social support, failing at school, or getting in trouble with the law. Encouragingly, the consistent pattern of the greatest progress being achieved by the group with the worst problems across all areas suggests that progress can be made with even the most difficult cases.

- **Progress Appears to Increase with Longer Program Participation**

Progress achieved in the program appears to increase with longer participation and appears to be lasting. Children who have been in the program longer show more progress than children who have been in only a short period. Furthermore, a previously completed study of children who have left the program after their 18th birthday suggests that the progress achieved is generally maintained when compared with higher violent and assaultive behavior in children who were not treated. More study of clients over time will be needed, as the assessment process is still relatively new.

- **The Most Progress is Made Early in Program Participation**

The ability of the program to produce progress is greatest in the first year of program participation. By the time many of the children get referred and certified in the **Willie M.** Program they have been in a period of decline. The program is able to quickly turn around some of the most significant problems, whether they are behavioral or residential in nature, to produce important change for the child early on. While improvement continues for most after the first year, progress is more difficult to achieve.

- **Program Participation Does Not Solve All Problems**

While progress is being made for these troubled children as a group, it is clear that participation in the program does not eliminate aggressive and non-social behavior for these children while still clients or after aging out of the program. Some children fully participating in the program still assault or threaten others, abuse drugs or

alcohol, and get in trouble with the law. The program does not cure these children or completely eliminate socially unacceptable behavior. Progress will always have to be measured in modest but clearly positive steps forward.

B. Assessment of **Willie M.** Children's Progress by Dimension

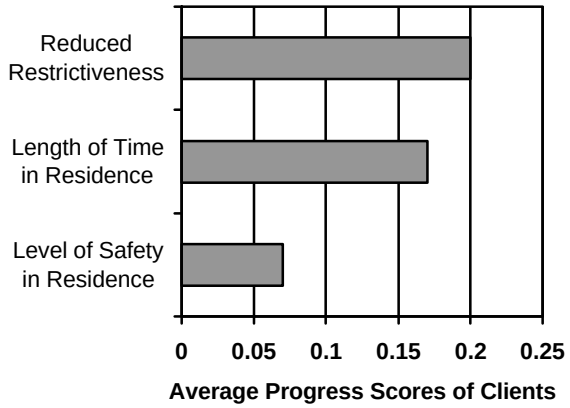
As noted in the introductory section to this report, the Department of Health and Human Services (DHHS) and the Department of Public Instruction (DPI) have a statement of desired outcomes for **Willie M.** children by the time they reach age 18. As part of the effort to assess desired outcomes for **Willie M.** clients, six dimensions or domains of desired outcomes were developed: Residential, Health, Behavioral, Social, Educational, and Vocational. These domains are consistent with those adopted by the Division of MH/DD/SAS for all clients of the mental health service system. A seventh domain, Legal, was added due to the frequency with which **Willie M.** children have contact with the juvenile or adult justice system. Following is a brief highlighting of some of the information about how these children are functioning and progressing along these seven outcome domains.

1. Residential Domain

The desired goal or outcome for this domain is for a client to have a "home," even if it is not his natural home, which provides him with a safe, nurturing environment conducive to the achievement of all of his other goals and objectives.

Three key aspects of the residential goal are to put clients in less restrictive settings, increase the stability or length of time in a residence, and to have a high degree of safety in the present residence. Progress is measured as the difference between the clients' most recent and initial assessments, with positive numbers indicating improvement and negative numbers showing regression. Assessment scores range from 1 to 5 for each child, so an average initial score of 3.5 and a more recent average assessment score of 3.7 would produce an average progress score of 0.2. As can be seen in FIGURE 10, on all three of these measures, progress is being made with the most gains being achieved in getting children into less restrictive settings. This improvement in level of restrictiveness was an important consideration for the federal court in dismissing the **Willie M.** lawsuit.

Figure 10
Assessments of Progress for Residential Domain



While the measure of level of safety shows less progress, the actual level of functioning is already very high with most clients already at the highest assessment of living in a residence that is always safe.

Placing children in the least restrictive environment appropriate for their needs is beneficial both for providing a supportive environment and for containing costs. **Willie M.** children live in a variety of settings. Based on an assessment done in the spring of 1998:

- 34 percent live at home,
- 16 percent live in alternative family living arrangements such as foster care,
- 32 percent live in group care facilities,
- 5 percent live in training school, jail, prison, or other detention facility,
- 4 percent are in secure treatment facilities, and
- the remaining 9 percent are in a variety of other settings.

Thus, half of the children are still in facilities requiring more than minimal levels of age-appropriate adult supervision. While placing children in less restrictive settings reduces expenses, this must be balanced against the safety needs of the child, family, and community. Periods of restriction are sometimes necessary to stabilize a child after which many can move to less restrictive environments.

2. Health Domain

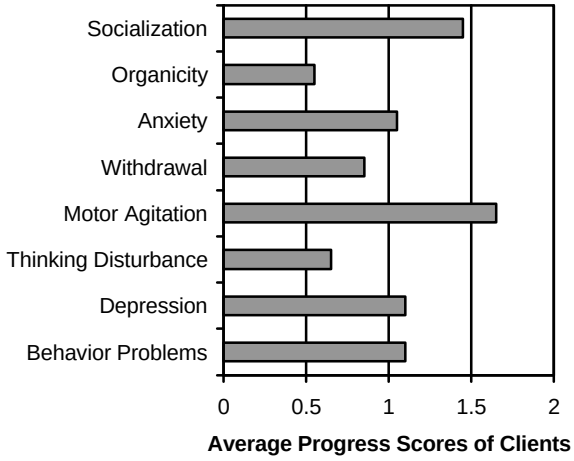
The desired outcome of the Health domain is that the client will, to the extent that he/she is able, maintain a state of health sufficient to his/her participation in normal, productive, and rewarding activities.

Most of the **Willie M.** clients enter the program very healthy and maintain their health over time. Those who entered with some degree of impairment from physical health problems have made large improvements early on and continued with slight gains while in the program.

Serious mental health problems are of course an ongoing concern for most of these children. Nevertheless, there are clear signs of progress here as well. As part of the ongoing assessment process, each child is evaluated using the Brief Psychiatric Rating Scale for Children (BPRS), a widely used scale to assess psychiatric symptoms of children such as uncooperativeness, hyperactivity, withdrawal, and anxiety. The average progress scores represent the difference between the most recent and the clients' initial assessments. BPRS scores can range from 1 to 7, so an average initial score of 3.8 and a most recent score of 5 would indicate an average progress score of 1.2. As can be seen in FIGURE 11, positive progress has been achieved in all of the eight dimensions measured by the BPRS with the greatest gains in the area of reduced motor agitation and better socialization.

The major non-mental health problem for most of these children is drug or alcohol abuse. The most recent available assessment found that 18 percent had been suspected of substance abuse in the prior three months. This represents a slight decline from the prior year where 20 percent had been suspected of substance abuse.

Figure 11
Progress in Reducing Psychiatric Symptoms

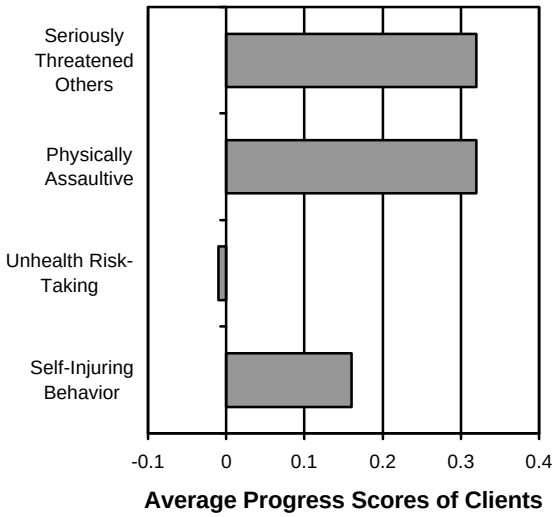


3. Behavioral Domain

The desired outcome for this domain is that the client develop the social competence and coping skills he/she needs in order to reduce or ameliorate assaultive and aggressive behaviors.

Reducing aggressive behavior is one of the most important goals for the **Willie M.** children. All of these children have exhibited violent or assaultive behavior, as this is one of the key eligibility requirements for becoming a program client. Aggression is a tenacious behavior, but children admitted to the **Willie M.** Program improve most dramatically in this area of behavior due in large part to the emphasis placed on teaching clients behavior management skills. Reducing violent behavior is an important goal in its own right but is equally important as a precursor to making progress in other areas such as education, residential placement, and justice system involvement. The average progress scores represent the difference between the most recent and the clients' initial assessments with positive numbers indicating progress and negative numbers indicating regression. As can be seen in FIGURE 12, three of the four key measures for the behavioral domain show progress for clients from their initial assessment to the most recent. On average, the most recent assessment shows clients

Figure 12
Progress in Behavioral Functioning



generally engaging in the behaviors less than once a month including engaging in unhealthy risk-taking behavior that showed a very slight regression.

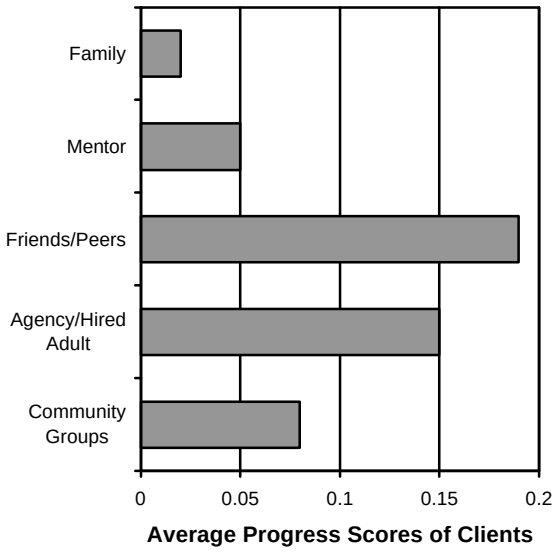
More detailed assessments completed show several important findings. First, those children who entered with the worst behavior problems occurring more frequently than once a month show the largest improvements and are generally able to lower their violent behavior to a level equal to the children with less frequent problems. Second, the largest improvements occur in the first year after the children are initially assessed, suggesting the changes the program puts in place can make dramatic differences early on. Finally, when looking at an array of specific violent behaviors, the longer a child stays in the program, the less frequently these behaviors occur indicating that progress continues the longer a child is in the program.

4. Social Domain

The desired outcome for the Social domain is for the client to have at least one adult who is an advocate, friend, and confidant who maintains a long-term relationship with the child, fostering trust, self-esteem, and social competence.

Most of the children entering the Program have little or only moderate support from their communities. Supportive social ties, with members of their family and community, provide valuable *protective factors* for Program clients. Staff in the **Willie M.** system work hard to help those who come to the Program from strained families and unsupportive communities to build enduring support networks. Social support is assessed in five different areas with progress being evident in each, although for some it is very slight as seen in FIGURE 13. Average progress scores represent the difference between the most recent assessments and initial assessments, with positive numbers indicating progress on average for all clients. Although the amount of progress is lowest for support from the family, this remains the source of the highest amount of support for clients in general. The value of supportive social ties has been consistently shown through research. The loss of community support for children who are placed

Figure 13
Progress in Increasing Social Support



outside their natural homes underscores the importance of providing alternative residential options close to home for those children who need them.

5. Educational Domain

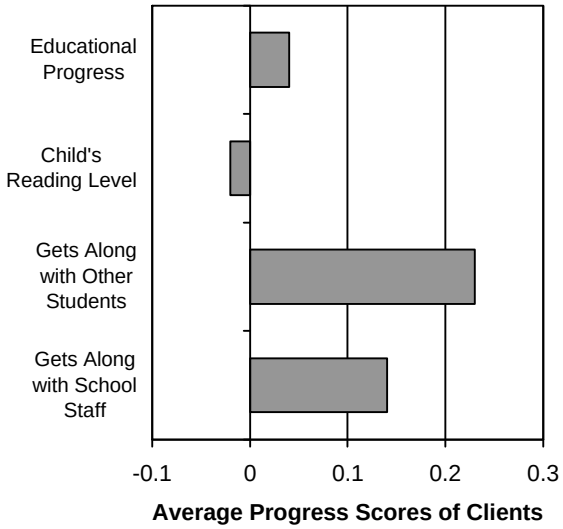
The desired outcome of the Educational domain is that the client attends and participates in educational services appropriate to his/her needs.

Education is a difficult area for most **Willie M.** children. For many, developmental disabilities or emotional disorders hamper or limit their academic potential. When clients enter the program, attention to emotional and behavioral problems is often needed before school problems can be addressed. For children who have performed well in the past, addressing their problems can disrupt their schooling.

Keeping children in school is the most obvious first need, and the **Willie M.** Program has made clear progress here. As noted earlier in the report, six years ago approximately 68 percent of Program clients were in public schools but this proportion had grown to 85 percent as of 1998. In addition, a number of other clients are in alternative non-public schools. Based on annual assessments, for children who were not enrolled in school a year earlier, eighty percent were in school in the most recent survey. For children not enrolled at their first survey, two to four years earlier, fully 96 percent were now in school.

Most of the clients enter the Program assessed as having significant educational problems or setbacks. On average, most are roughly two grades below their expected reading level. Progress has been achieved, particularly at helping Program clients get along better with other students and teachers, which may facilitate learning later. The improvements in reducing aggressive and violent behaviors clearly translate into an improved ability to get along with other students and school staff. As can be seen in FIGURE 14, there was slight regression on average for clients' reading levels from their initial to most recent assessments.

Figure 14
Educational Progress



6. Vocational Domain

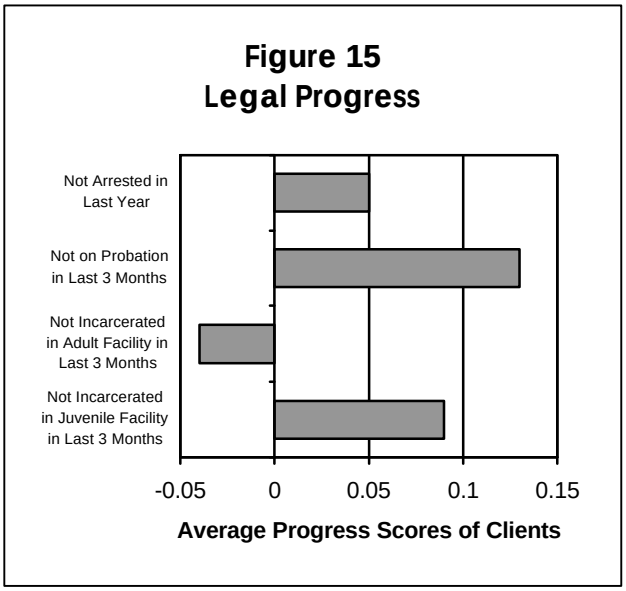
The desired outcome of the Vocational domain is for the client to be engaged in meaningful employment in a real work setting of his/her choice, or in activities leading toward that goal. The Vocational domain goal is less critical for **Willie M.** clients because they are children, but it was kept to be consistent with the broad goals adopted by the Division of MH/DD/SAS for all clients of the mental health service system.

For most children, staying in school is the key means to further the desired outcome in the vocational domain, so the progress being achieved there is important. However, some children are not in school for a variety of reasons or choose to engage in work. Based on a complete survey of clients in the spring of 1998, 11 percent of the **Willie M.** children were gainfully employed and earning money for their work. Given that current employment is not a primary goal and that most clients are under the age of 15, the small percent who are employed should not be seen as a low number.

7. Legal Domain

The desired outcome for the Legal domain is that the child function in the community with a minimum of contact with social control agencies ranging from the police to the court system.

Since **Willie M.** Program eligibility requires evidence of violent assaultive behavior, contact with the law is an ongoing concern for these children. Nevertheless, most of these children manage to stay out of trouble after becoming program clients. As of assessment data for 1998, 76 percent of the children had not had any contact with law enforcement in the last three months, 90 percent had not been arrested in this time, and 93 percent had not been convicted of any crime during the three months. However, many of the children have ongoing legal problems. One-fourth of the children or 27 percent are currently on probation, 2 percent are in training school, and another 2 percent are in jail or prison.



There has been improvement in some areas of legal outcomes. Fewer are being arrested, placed on probation, or placed in juvenile detention. The average progress scores in FIGURE 15 show the difference between the most recent and initial assessments with positive

numbers indicating progress. The legal scores range from 1 to 2, so the average level of progress represents the proportion of clients not having the problems compared to their initial assessments. There has been regression in the numbers of clients incarcerated in an adult facility over the last three months, but as already noted, very few of the clients are in adult correctional facilities. There is no evidence that this suggests a trend of great concern at this time. Of children who had been arrested prior to entering the program, over two-thirds remained arrest-free since they started. Of the majority of clients who had not been arrested prior to entering the program, less than one-fifth had been arrested during the year prior to administration of their most recent assessment.

Across all of the key areas of concern, progress is being made at getting clients to higher levels of functioning whether that means less violent behavior, staying in school, or getting children into less restrictive residential settings. The **Willie M.** Sections of DHHS and DPI will continue to move forward in monitoring and analyzing outcomes to more clearly understand what helps children make progress and implement useful improvements in treatment and systems operations.

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